westernhealth ADVANTAGE

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

COVERED CALIFORNIA™

INDIVIDUAL | 2024

EFFECTIVE OCTOBER 19, 2023

Please note that effective October 19, 2023, the Combined Evidence of Coverage and Disclosure Form (EOC/DF) was updated to revise and replace the sections below within the EOC/DF. This is not a reduction in coverage or benefits.

If you have any questions, please feel free to contact our Member Services Department.

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Pediatric Vision Services and Special Contact Lenses are covered as described below for Members until the end of the month in which the member turns 19 years of age.

Examinations are covered through your Medical Group. One comprehensive eye examination per year (including refraction, and dilation if medically indicated) is covered at no cost. Annual eye exams do not require a referral, but Members must select a Participating Provider. Certain vision exams may require a referral from your PCP.

Glasses, lenses, elective contact lenses and low vision devices are generally covered through EYEXAM, except as specifically noted below. The following are covered by EYEXAM at no cost:

- One pair of glasses with standard lenses (plastic, glass or polycarbonate); or
- One pair of standard hard or six pairs of standard soft contact lenses per calendar year instead of glasses
- One pair of Medically Necessary contact lenses (except as noted below).

Lenses covered at no cost include single vision, conventional bifocal, conventional trifocal or lenticular lenses as prescribed.

Medically Necessary contact lenses require prior authorization. Examinations are covered by your Medical Group. Once your Medical Group Participating Provider has determined you need Medically Necessary contact lenses, they will be covered by EYEXAM.

Expanded benefit for Aniridia and Aphakia: Up to two Medically Necessary contact lenses per eye are covered in any 12-month period to treat Aniridia. Up to six Medically Necessary contact lenses per eye are covered per calendar year to treat Aphakia including fitting and dispensing.

For children with low vision (defined as a significant loss of vision but not total blindness), one (1) pair of high-power spectacles per calendar year and a lifetime maximum of one (1) magnifier and one (1) telescope are covered at no charge, with prior authorization.

As described above, most glasses and contact lenses benefits and low vision devices are provided by EYEXAM. To obtain glasses, contacts, or low vision devices through EYEXAM under the pediatric vision benefits, you must obtain the eyewear from an EYEXAM Participating Provider. Please refer to mywha.org/directory or to a current EYEXAM Provider Directory. It is your responsibility to identify yourself or the Member as having an EYEXAM plan.

All claims for reimbursements for glasses or contacts must be submitted to EYEXAM within six months after date of service.

To obtain Medically Necessary contact lenses through your Medical Group as described above, you must obtain a referral from your Medical Group.

Please see your Copayment Summary for additional information.

Please contact EYEXAM’s Customer Service Department at 844.844.0891 for inquiries about benefits, covered services or providers.

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Benefit Questions and Clarifications

WHA strives to provide exceptional health care services to you. If you have a concern about your medical care, you should discuss it with your PCP. If you need help answering your questions or clarifying procedures, call Member Services toll-free at 888.563.2250 between 8 a.m. and 6 p.m. Monday through Friday, or visit or write to:

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

A Member Services representative will research and respond to your questions. If you are not satisfied with the response or action taken, you may submit an Appeal or Grievance (see “Appeal and Grievance Procedure” below).

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Grievances Related to Pediatric Vision Benefits

If you have a complaint or grievance regarding your pediatric vision benefits relating to eye exams or vision prescriptions, contact WHA Member Services toll-free at 888.563.2250 or you can submit a complaint or grievance to:

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

If you have a complaint or grievance regarding your vision materials benefits (such as eyeglasses or contacts), complaint forms may be obtained from EYEXAM, WHA, the subscriber group, participating provider’s office, by visiting mywha.org/grievance, and/or requested by calling EYEXAM’s Customer Service at 844.844.0891. Grievances can be submitted to:

EYEXAM
Attn: Quality Assurance
4000 Luxottica Place
Mason, OH 45040

Or Fax: 1.513.492.3259

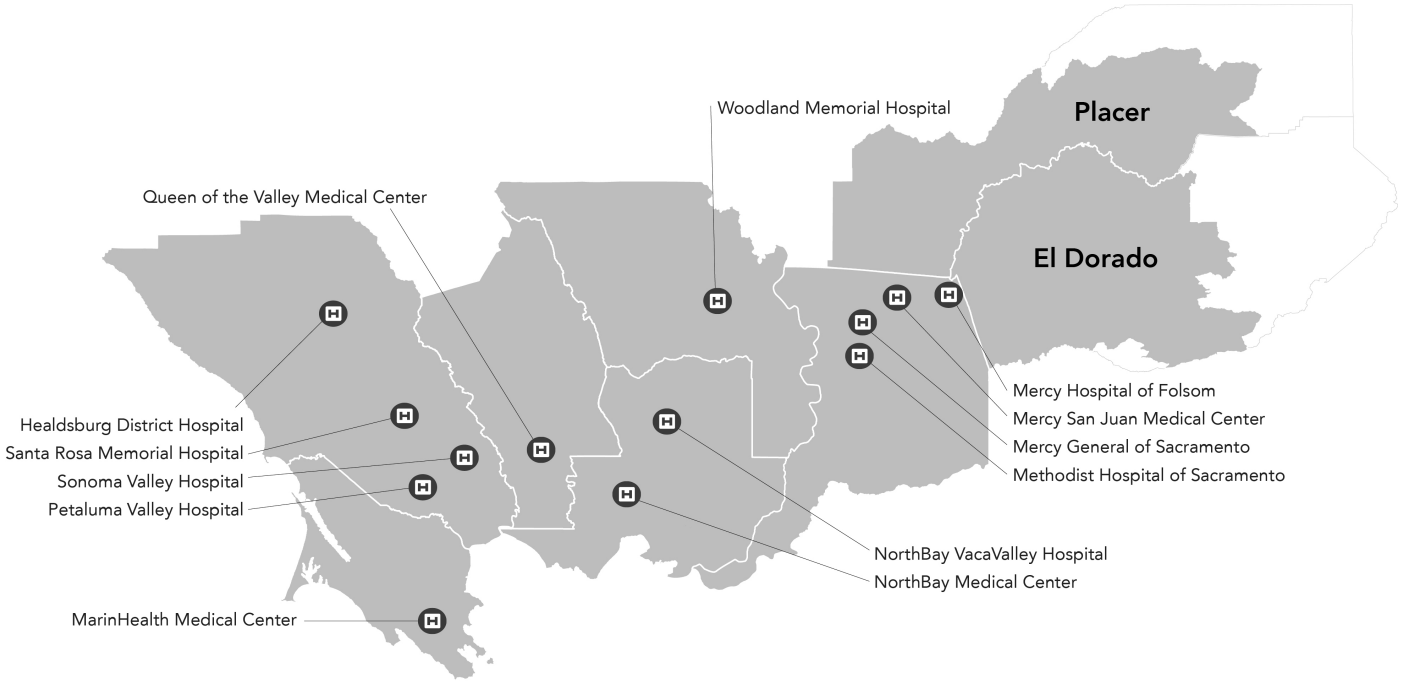
CHANGES FOR 2024

Please make note of the following changes and/or clarifications to the Combined Evidence of Coverage and Disclosure Form for 2024. This list assists members to identify key changes. It is not intended to be a comprehensive list of changes.

Changes

P 3	Amendment to section “Principal Benefits and Covered Services” section of Table of Contents
P 9	Amendment to section “Selecting Your Primary Care Physician” to clarify when non-urgent care or non-emergency should be received from PCP or other Participating Provider as referred by PCP
P 10	Amendment to section “Changing Your Primary Care Physician” to clarify notice provided when changing PCP
P 21, 22	Amendment to section “Family Planning” under “Principal Benefits and Covered Services” to comply with State law
P 23	Amendment to section “Inpatient Services” under “Principal Benefits and Covered Services” to clarify requirements for inpatient hospitalization
P 24, 25	Amendment to section “Mental Health and Substance Use Disorder Services” to clarify what services are covered and update information for new behavioral health provider
P 29	Amendment to section “Submitting Prescription Claims for Reimbursement” to comply with state law
P 33, 34	Amendment to section “Pediatric Vision Services and Special Contact Lenses” to clarify pediatric vision benefits.
P 34	Amendment to section “Principal Exclusions and Limitations” to clarify what services are excluded
P 39	Amendment to section “Eligible Dependents (“Family Members”) and Age Limits” to clarify requirements eligibility requirements.
P 52, 53	Amendment to section “Grievances Related to Pediatric Vision Benefits” to update information for new vision provider
P 53	Amendment to section “Grievances Related to Mental Health and Substance Use Disorder Benefits” to update information for new behavioral health provider
P 64-68	Amendment to “Appendix A” to update list of preventive services and criteria for same
Various	Change “Behavioral Health” to “Mental Health and Substance Use Disorder”
Various	Change “NurseLine” to “Fonemed” for 24/7 nurse advice line
Various	Update contact information for TTY telephone number
Various	Update contact information for interpreter services
Various	Change “MESVision” to “EYEXAM of California, Inc.” (EYEXAM) to update vision health provider
Various	Update contact information for Fonemed nurse advice line

WHA SERVICE AREA MAP



Western Health Advantage is licensed in the following zip codes in the following counties:

El Dorado	partial coverage — 95613, 95614, 95619, 95623, 95633, 95634, 95635, 95636, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726, 95762
Marin	All Zip Codes
Napa	All Zip Codes
Placer	partial coverage — 95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95722, 95736, 95746, 95747, 95765
Sacramento	All Zip Codes
Solano	All Zip Codes
Sonoma	All Zip Codes
Yolo	All Zip Codes

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NOTICE OF LANGUAGE ASSISTANCE

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 711.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 711 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 711。

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 711.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 711.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 711로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 711՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث اَدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره711 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 711.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、711までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 711.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 711 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន
នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកក្រចៀកថ្លង់ តាមលេខ 711។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 711.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 711 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 711

INTRODUCTION

We at WHA are pleased that you have chosen our health plan for your medical needs. The information in this Combined Evidence of Coverage and Disclosure Form (EOC/DF) was designed for you as a new Member to familiarize you with WHA. It describes the Medical Services available to you and explains how you can obtain treatment. If you want to be sure you have the latest version of the EOC/DF, go to westernhealth.com and sign in through Personal Access to see plan materials for your coverage.

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

This EOC/DF constitutes only a summary of your health plan. The Agreement between you and Covered California must be consulted to determine governing contractual provisions as to the exact terms and conditions of coverage. 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 the number listed below.

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

This EOC/DF, the Individual/Family Enrollment Application and Membership Agreement and benefits are subject to amendment in accordance with the provisions of the EOC/DF without the consent or concurrence of Members.

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

WHA's failure to enforce any provision of this EOC/DF will not constitute a waiver of that or any other provision of this EOC/DF.

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

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

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

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

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

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

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

Confidentiality of Medical Records

A STATEMENT DESCRIBING WHA'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Public Policy Participation

WHA's Public Policy Committee is responsible for participating in establishing public policy for the plan. If you would like to provide input for consideration by the Public Policy Committee, you may send written comments to:

Attn: Public Policy Committee
Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

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; or abortion. 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 the number listed below to ensure that you can obtain the health care services that you need.

WHA Participating Providers include a wide selection of PCPs, specialists, hospitals, laboratories, pharmacies, ambulance services, skilled nursing facilities, home health agencies, and other ancillary care services. WHA provides printed Provider Directories upon request. However, as the Directory is updated changes may have occurred that could affect your Physician choices. If you need a copy of the directory, contact Member Services at the number listed below or by email or in writing. To view our online Provider Directory, WHA's website address is westernhealth.com.

Liability of Member for Payment

Copayments

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

For some Covered Services, you pay the Copayment until your annual out-of-pocket maximum is reached. For Covered Services that are subject to the Deductible, you pay the Copayment only after the Deductible is met. See the discussion of the Deductibles and annual out-of-pocket maximum below and in the "Financial Considerations" section of this EOC/DF for more information.

You may also have one or more Deductibles. Please refer to the section of this EOC/DF titled "Financial Considerations," "Deductibles."

Emergency Services

Whether provided by Participating or non-Participating Providers, WHA covers your emergency services, and your only liability is the applicable copayment and/or deductible.

Your Liability for Payment

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

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

Participating Providers

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

Non-Participating Providers

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

HOW TO USE WHA

Selecting Your Primary Care Physician

When you enroll in WHA, you must select a Primary Care Physician (PCP) from one of WHA's Medical Groups for yourself and each of your covered Family Members. Each new Member should select a PCP close enough to his or her home or place of work to allow reasonable access to care. You may designate a different PCP for each Member if you wish. Your PCP is responsible for coordinating your health care by either direct treatment or referral to a participating specialist. With the exception of the limited list of services approved for direct access to care referenced within the "Participating Providers" section, all non-Urgent Care or non-Emergency Care should be received from your PCP or other Participating Provider as referred by your PCP.

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

The types of PCPs you can choose include:

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

***Note:** Not all internal medicine physicians, pediatricians, pediatric subspecialists and

obstetrician/gynecologists are designated PCPs. Some may practice only as Specialist Physicians. Visit westernhealth.com to search for PCPs in your preferred specialty.

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

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

Note: Regardless of which Medical Group your PCP is affiliated with, you may be able to receive services from participating specialists in other Medical Groups / IPAs. See “Advantage Referral“ below.

Your Medical Group may have rules that require Members in certain areas or assigned to certain PCPs to obtain some ancillary services, such as physical therapy or other services, from particular providers or facilities. For example, selecting a PCP from UC Davis Medical Group does not assure that a Member would have access to UC Davis physical therapy clinics.

Changing Your Primary Care Physician

Since your PCP coordinates most of your Covered Services, it is important that you are completely satisfied with your relationship with him or her. If you want to choose a different PCP, call Member Services **before** your scheduled appointment. Member Services will ask you for the name of the Physician and your reason for changing. **Note:** Generally, Members aged 18 and older are responsible for submitting their own PCP change requests (another adult family member cannot submit the request on their behalf).

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

Transferring to another Primary Care Provider or Medical Group

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

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

Referrals to Participating Specialists

If medically appropriate, your PCP will provide a written referral to your selected participating specialist. Please remember that if you receive care from a participating specialist without first receiving a referral (or if you see a non-participating specialist without Prior Authorization - see “Prior Authorization”

below), you may be liable for the cost of those services. You will receive a notification of the details of your referral to a participating specialist and the number of visits as ordered by your Physician. 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 are included in the Advantage Referral program and do not require a PCP referral or Prior Authorization, as long as the provider is listed in the WHA Provider Directory and participates in the Advantage Referral program.

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

Advantage Referral

In order to expand the choice of physician specialists for you, WHA implemented a unique program called "Advantage Referral". The Advantage Referral program allows you to access **some of the Specialist Physicians within your network (as listed in the Provider Directory)**, instead of limiting your access to those specialists who have a direct relationship with the Member's PCP and Medical Group. While your PCP will treat most of your health care needs, if your PCP determines that you require specialty care, your PCP will refer you to an appropriate provider. You may request to be referred to any of your network specialists who participate in the Advantage Referral program. Your WHA Provider Directory designates the providers who do not participate in the Advantage Referral program, or you may call Member Services.

Contact your PCP or refer to the Provider Directory to confirm that a particular specialist is available to you.

Services that Do Not Require A Referral

WHA wants to make it easier for you to receive the right care, at the right time, and in the right place—with the best services available. The following services, when obtained from a participating provider, do not require a referral from your PCP:

- On-call Physician Services: The on-call physician for your PCP can provide care in place of your physician.
- MHSUD Services: See the back of your WHA ID card for the telephone number for your MHSUD benefits provider or visit mywha.org/bh.
- Gynecology/Obstetrical Services
- Vision: An annual eye exam (when covered)
- Emergency Care: If you are in an emergency situation, call 911 or go to the nearest hospital emergency room. Notify your PCP the next business day or as soon as possible.
- Urgent Care: When an urgent care situation arises while you are in WHA's Service Area, call your PCP at any time of the day, including evenings and weekends.
- Services or items to mitigate diseases declared a public health emergency.

WHA also offers all members access to California-licensed, registered nurses through Fonemed. Screening, triage, and health education services are available 24 hours a day, 7 days a week. Use Fonemed to help answer questions about a medical problem you may have, including:

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

Prior Authorization

Certain Covered Services require Prior Authorization by WHA or its Medical Group in order to be covered. Your PCP must contact the participating Medical Group with which your PCP is affiliated or, in some cases, WHA to request the service or supply be

approved for coverage before it is rendered. If Prior Authorization is not obtained, you may be liable for the payment of services or supplies. Requests for Prior Authorization will be denied if the requested services are not Medically Necessary as determined by WHA or the Medical Group, or are requested with a non-Participating Provider and a Participating Provider is available to supply Medically Necessary services for the Member.

Prior Authorization is required for:

- Services from non-Participating Providers except in Urgent Care situations arising outside WHA's Service Area or Emergency situations. For example, a Covered Service may be Medically Necessary but not available from Participating Providers, or a Participating Specialist, MHSUD provider, or acupuncturist may not be geographically accessible to a member. Then, your Physician must obtain Prior Authorization from WHA or its delegated Medical Group before you receive services from a non-Participating Provider;
- Care with a Specialist Physician that extends beyond an initial number of visits or treatments;
- Physical therapy, speech therapy and occupational therapy;
- Rehabilitative services (cardiac, respiratory, pulmonary);
- All hospitalizations;
- All surgeries (except surgeries performed to stabilize an emergency medical condition);
- Non-emergent medical transport or ambulance care;
- Second medical opinions;
- Some prescription medications (if prescriptions are covered under your plan, prescription medication prior authorization requests are completed within 72 hours for routine requests and 24 hours for urgent requests);
- Fertility Preservation for Iatrogenic Infertility;
- Most scheduled tests and procedures (ask your PCP);
- Other services if your Medical Group requires Prior Authorization (ask your PCP);
- Medically necessary contact lenses; and
- MHSUD inpatient, residential treatment, and non-routine outpatient services including outpatient electroconvulsive therapy, intensive outpatient program, partial hospitalization program, psychological testing, repetitive transcranial magnetic stimulation, and Behavioral Health Treatment for Autism Spectrum Disorder including Applied Behavioral Analysis (ABA).

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

Your WHA ID card lets your provider know that you are a WHA Member and that certain services will require Prior Authorization. If you do not present your ID card each time you receive services, he/she may fail to obtain Prior Authorization when needed, and

you could be responsible for the resulting Charges. Your Physician will receive written notice of authorized or denied services and you will be notified of any denials. If Prior Authorization is not received when required, you may be responsible for paying all the Charges. Please direct your questions about Prior Authorization to your PCP.

Second Medical Opinions

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

All requests for second medical opinions should be directed to the Member's PCP. Members may also contact WHA's Member Services Department at the number listed below for assistance or for additional information regarding second opinion procedures. Decisions regarding second medical opinions will be authorized or denied within the following timelines:

- Urgent/emergent conditions – within one (1) working day
- Expedited condition – within seventy-two (72) hours
- Elective conditions – within five (5) working days

Urgent Care and Emergency Care

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

If Emergency Care is obtained from a non-Participating Provider, WHA will reimburse the provider for Covered Medical Services received for Emergency situations, less the applicable Copayment and/or Deductible.

If an Urgent Care situation arises while you are outside of WHA's Service Area, WHA will reimburse a non-Participating Provider for Covered Medical Services to treat the Urgent Care situation, less the applicable Copayment. If you have an Urgent Care situation in WHA's Service Area, you must contact your PCP's office for direction about where to go for Urgent Care treatment within the contracted network.

If an **Emergency** situation arises whether you are in WHA's Service Area or outside of the Service Area, call "911" immediately or go directly to the nearest hospital emergency room. If an **Urgent Care** situation arises while you are in WHA's Service Area, call your PCP. You can call your doctor at any time of the day, including evenings and weekends or call WHA's nurse advice line by calling 888.656.3574. Explain your condition to your doctor, the Physician on call at your doctor's office, or the nurse on the nurse advice line and he/she will advise you. In the event you are not able to reach your Physician or the nurse advice line, you may go to an Urgent Care facility affiliated with your Medical Group. For more information about the nurse advice line, please see "Principal Benefits and Covered Services," "Other Health Services."

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

Post-Stabilization Care

Once your Emergency Medical Condition is stabilized, your treating health care provider at the hospital emergency room may believe that you require additional post-stabilization services prior to your being safely discharged. If the hospital is a non-Participating Hospital, the hospital will contact your assigned Contracted Medical Group or WHA to obtain timely Prior Authorization for these post-stabilization services. If WHA or its Contracted Medical Group determines that you may be safely

transferred to a Participating Hospital and you refuse to consent to the transfer, you will be financially responsible for 100% of the cost of services provided to you at the non-Participating Hospital after your Emergency Medical Condition is stable. Also, if the non-Participating Hospital is unable to determine your name and WHA contact information in order to request Prior Authorization for post-stabilization services, it may lawfully bill you for such services. If you feel that you were improperly billed for services that you received from a non-Participating Hospital, please contact WHA Member Services.

Follow-Up Care

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

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

Timely Access to Care

Health plans in California must meet timelines for providing care and services to members seeking treatment. The Timely Access Regulations set specific standards for patients to obtain a medical appointment in certain situations. The standards are shown below.

- **Appointment Availability Standards By Request for Care Type**
- **Visit For Primary Care**
  - Routine: 10 business days
  - Urgent: 48 hours
- **Referral for visit to medical or MHSUD specialist**
  - Routine: 15 business days
  - Urgent: 48 hours if no prior authorization required
  - Urgent: 96 hours if prior authorization required
- **Visit with non-physician MHSUDprovider**
  - Routine or follow-up: 10 business days
- **Follow-up visit with a non-physician MHSUD provider when undergoing a course of treatment for an ongoing mental health or substance use disorder condition**
  - Routine: 10 business days from the prior appointment
- **Ancillary services (such as lab tests and x-rays) for diagnosis or treatment of injury, illness or other health condition**
  - Routine: 15 business days
- **Telephone triage and screening services with a health professional***
  - Routine/Urgent: Waiting time cannot exceed 30 minutes
- **Speaking with a WHA member service representative by phone during normal business hours**
  - Routine/Urgent: Waiting time cannot exceed 10 minutes

*WHA members can reach the Fonemed nurse advice line 24 hours per day, 7 days per week, 365 days per year by calling 888.656.3574.

Exceptions to the Appointment Availability Standards

Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

Extending Appointment Waiting Time: The applicable waiting time for a particular appointment

may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.

Advanced Access: The primary care appointment availability standard in the chart may be met if the primary care physician (PCP) office provides "advanced access." "Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

If You Need Help Obtaining Timely Care

If you need help obtaining timely care:

- First, contact your PCP or the referring provider for assistance. They may secure an appointment or find another provider that can see you sooner. Your provider may also decide that a longer waiting time will not be detrimental to your health.
- If your provider is not able to assist, contact WHA's Member Services.

Cultural and Linguistic Services

WHA and our providers support your right to obtain accessible health care. If you have needs with regard to your culture, language, or a disability, please contact your physician's office first or call WHA's Member Services.

If you need assistance in a language other than English, your doctor's office and WHA offers interpretation services in many languages, including Spanish and American Sign Language—let your physician's office know when you call for an appointment. View the Notice of Language Assistance for more information and assistance from Member Services. The deaf and hard of hearing may use their provider's or WHA's TTY line at 711.

Additional information about access to care and how to obtain a referral or prior authorization is available at mywha.org/planbasics and your EOC.

Interpreter services are also available upon request by calling 888-563-2250. You can chat with a nurse by visiting mywha.org/nurseadvice.

Provider Network Adequacy

WHA will ensure the provider network is in sufficient numbers to assure that all Covered Services are accessible without unreasonable delay, which includes access to Emergency Services twenty-four (24) hours a day, seven (7) days per week.

Direct Access to Qualified Specialists for Women's Health Services

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

Access to Specialists

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

Transition of Care and Continuity of Care

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

- An acute condition (care continued for the duration of the acute condition).
- A serious chronic condition. A serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered Services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the Member and the terminated provider or non-Participating Provider, consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
- A pregnancy (care continued for the duration of the pregnancy and the immediate postpartum period including a documented maternal mental health condition (care continued no longer than twelve (12) months from the end of the pregnancy)).
- A terminal illness, an incurable or irreversible condition that has a high probability of causing death within one year (care continued for the duration of the terminal illness).
- Care of a newborn child whose age is between birth and thirty-six (36) months (care continued for a period not to exceed twelve [12] months).
- Performance of surgery or other procedure that has been authorized by WHA or the Medical Group as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

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

WHA and/or the Medical Group will notify you of the provider's termination and 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. Facility-based services must be provided by a licensed hospital or other licensed health care facility. If the terminated provider does not comply with these contractual terms and conditions, WHA will not continue the provider's services beyond the contract termination date, and you will not be eligible to continue care with that provider.

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

continue the provider's services, and you will not be eligible to continue care with that provider.

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

If you believe that your medical condition meets the criteria for continuity of care outlined above, you may be entitled to continue your care with your current provider. Please contact the WHA Member Services Department prior to enrollment, within 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. Continuity of Care requests received more than thirty (30) days from the Effective Date of your WHA coverage or from the date your provider terminated with WHA will be evaluated by WHA's Medical Director or delegate. You also may go to WHA's web page, westernhealth.com, to obtain a copy of the Continuity of Care form. Complete and return this form to WHA as soon as possible. After receiving the completed form, WHA will notify you if you qualify for continuity of care with your provider. If you do qualify for continuity of care, you will be provided with the appropriate plan for your care. If you do not qualify, you will be notified in writing and offered alternative Participating Providers. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis. To request a copy of our continuity of care policy, please call our Member Services Department the number listed below.

Your Medical Group must preauthorize or coordinate services for continued care. If you have any questions or want to appeal a denial, call our Member Services Department at the number listed below, Monday through Friday, 8 a.m. to 6 p.m.

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

Access to Emergency Services

Members have the right to access Emergency Services, including the "911" emergency response system, when and where the need arises. WHA has processes in place which ensure payment when a Member presents to an emergency department with acute symptoms of sufficient severity – including severe pain – such that the Member reasonably expected the absence of medical attention to result in placing the Member's health in serious jeopardy.

MEMBER RIGHTS AND RESPONSIBILITIES

General Information

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

What Are My Rights?

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

- To be provided information about WHA's organization and its services, providers and practitioners, managed care requirements, processes used to measure quality and improve Member satisfaction, and your rights and responsibilities as a Member.

- To be treated with respect and recognition of your dignity and right to privacy.
- To actively participate with practitioners in making decisions about your health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending Physician.
- To expect candid discussion of appropriate, or Medically Necessary, treatment options regardless of cost or benefit coverage.
- To voice a Complaint or to appeal a decision to WHA about the organization or the care it provides, and to expect that a process is in place to assure timely resolution of the issue.
- To make recommendations regarding WHA's Member Rights and Responsibilities policies.
- To know the name of the Physician who has primary responsibility for coordinating your care and the names and professional relationships of others who may provide services, including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures.
- To receive information about your illness, the course of treatment and prospects for recovery in terms that can be easily understood.
- To receive information about proposed treatments or procedures to the extent necessary for you to make an informed consent to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment, medically significant risks associated with it, alternate courses of treatment or non-treatment including the risks involved with each and the name of the person who will carry out a planned procedure.
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with your care, except as permitted by law or as necessary in the administration of the Health Plan. WHA's policies related to privacy and confidentiality are available to you upon request.
- To full consideration of privacy and confidentiality around your plan for medical care, case discussion, consultation, examination and treatment, including the right to be advised of the reason an individual is present while care is being delivered.
- To receive or submit a claim for Sensitive Services without having to obtain another individual's authorization, provided you may consent to the care.
- To confidentiality of your medical information, including Sensitive Services, unless you have provided express written consent for that information to be disclosed.
- To obtain a request for confidential communication of your medical information, contact our Member Services department at 1.888.563.2250 or visit our website at westernhealth.com/legal/privacy to access the form. Your request may be submitted over the phone or the form can be submitted via mail, fax, or email as listed below:

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

  Fax: 916.568.0126

  Email: memberservices@westernhealth.com (include in subject line "Confidential Communications Request")
- Once your request is received, within 7 calendar days of an electronic transmission or telephone request or 14 calendar days of a first-class mailed request, all further communications will be made to the mailing address, email, or telephone number specified in the request form. If no alternative mailing address, email, or telephone number is provided, all further communications will be made at the mailing address or telephone number on file. This information will not be

shared with the Subscriber or any eligible dependent other than you, unless otherwise noted. The confidential information request is valid until you submit a revocation of the request or a new confidential information request is submitted.

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

What Are My Responsibilities?

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

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

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

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

PRINCIPAL BENEFITS AND COVERED SERVICES

WHA covers the services in this section when Medically Necessary. Services must be provided by one of the following:

- Your PCP;
- A Participating Specialist Physician when your PCP gives you a referral (first three visits need a referral only additional visits require Prior Authorization - see “How to Use WHA” “Prior Authorization”);
- Other Participating Providers when your PCP gives you a referral;
- Participating or non-Participating Providers who have been authorized by your Medical Group or USBHPC (see “How to Use WHA” “Prior Authorization”);
- A participating OB/GYN within your Medical Group or outside of your Medical Group if the OB/GYN participates in Advantage Referral (see “How to Use WHA” “Referrals to Participating Specialists”);
- A USBHPC Participating MHSUD Services Provider (see subsection “Prior Authorization” under “How to Use WHA”);
- An EYEXAM of California, Inc. (“EYEXAM”)” Participating Pediatric Vision Provider providing pediatric vision services (see “Other Health Services”).

WHA covers Emergency Care services as described under the section entitled “How to Use WHA,” in the subsection entitled “Urgent Care and Emergency Services.”

You will be responsible for applicable and/or Deductibles as described on your Copayment Summary or in this EOC/DF. You are also responsible for Charges related to non-Covered Services or limitations.

Note: Refer to the “Principal Exclusions and Limitations” section of this EOC/DF for a full description of exclusions and limitations.

Medical Services

Outpatient Services

WHA covers the following outpatient services.

- Office visits for adult and pediatric care, well-baby care, and immunizations;
- Pre-natal and post-partum maternity care, including coverage for prenatal diagnosis of genetic disorders of the fetus, coverage for tests for specific genetic disorders for which genetic counseling is available, and coverage for testing under the state California Prenatal Screening Program;
- Gynecological exams;
- Surgical procedures;
- Periodic physical examinations;
- Office visits for consultations or care by a non-participating specialist when referred and authorized by WHA or your Medical Group;
- Laboratory, X-rays, electrocardiograms and all other Medically Necessary tests;
- Therapeutic injections, including allergy testing and shots;
- Health education and family planning services, including counseling and examination;
- Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance and Medically Necessary;
- Sterilization services.
- Rehabilitative services including individual/group physical therapy, speech therapy and occupational therapy, when authorized in advance and Medically Necessary (including aquatic therapy and massage therapy, when these therapies are provided as part of physical therapy);
- Habilitative services, when medically necessary. Habilitative services means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include individual/group therapy for a child who is not walking or talking at the expected

age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

- Limits on Rehabilitative and Habilitative services will not be combined.
- Fertility preservation is covered for members who will be undergoing a medically necessary treatment that can result in infertility.

Note: Even if you stay in a hospital overnight, you might still be considered an outpatient. Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects which Copayments apply.

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.
- You are an outpatient if you doctor has not written an order to admit you to a hospital as an inpatient. This is considered "observation" and is an outpatient service. In these cases, you are considered an outpatient even if you spend the night at the hospital.

Preventive Services and Immunizations: Appendix A lists Preventive Services and Immunizations covered by WHA, and includes services and immunizations that are required to be covered by law. Preventive Services and Immunizations are covered with no copayment or cost sharing. WHA uses the recommendations of the United States Preventive Services Task Force (USPSTF) to establish Preventive Services benefits. Items rated A or B by the USPSTF for the individual seeking services are generally covered and listed in Appendix A. The USPSTF recommendations are available at www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are generally covered and listed in Appendix A. Appendix A does not list all covered immunizations. You may refer to the complete list of recommended immunizations at www.cdc.gov/mmwr/preview/mmwrhtml/rr5515a1.htm

Preventive care and screenings recommended by the Health Resources Services Administration (www.hrsa.gov/womensguidelines) are also generally included as benefits and listed in Appendix A.

Note on Annual Influenza Immunizations: In addition to the coverage described in this section, your Medical Group may reimburse annual influenza immunizations obtained from a provider other than your PCP. You may contact your Medical Group for more information on the availability of this expanded benefit.

For an office visit to be considered "preventive," the service must have been provided or ordered by your PCP, or a Participating OB/GYN within your Medical Group (or who participates in Advantage Referral). In addition, the primary purpose of the office visit must have been to obtain the preventive service. In the event you receive additional services that are not part of the preventive exam (for example, procedures or labs resulting from screenings or in response to your medical condition or symptoms), you will be responsible for the cost of those services as described in your Copayment Summary. WHA and its Medical Groups may manage your care by limiting the frequency, method, treatment or setting for Preventive Services and Immunizations.WHA does not cover any medications or supplements that are generally available over the counter, except for folic acid and aspirin in certain circumstances, and FDA approved contraceptives described under the heading "Family Planning". This applies even if you have a prescription for the item. Refer to Appendix A for more detail. Your plan may provide additional preventive services at no cost to you; consult your Copayment Summary for more information.

Family Planning: WHA covers all FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as

prescribed by the enrollee's provider. This includes clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, and follow-up including, but not limited to, managing side effects, ensuring adherence, and services related to device removal.

All FDA-approved contraceptive drugs, devices and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, are covered with no copayment or cost sharing. This includes:

- birth control pill;
- birth control patch;
- birth control injection;
- birth control implant;
- birth control sponge;
- female condoms;
- spermicide;
- diaphragm;
- cervical cap;
- emergency contraception pill
- vaginal contraceptive ring
- intra-uterine device (IUD)
- sterilization procedures
- sterilization Implant

WHA covers up to a 12-month supply, dispensed at one time, of the birth control pill, birth control patch, and vaginal contraceptive ring if your Physician prescribes a 12-month supply or 12 refills on a one-month supply prescription.

Note: If an item or service is prescribed for purposes other than contraception, a copayment or cost sharing may apply.

Abortion and Abortion-Related Services: WHA covers abortion and abortion-related services with no cost-sharing requirement.

Breastfeeding Support: WHA covers counseling and supplies during pregnancy and postpartum. This includes breast pump rental. WHA provides benefits in conjunction with each birth with no copayment or cost sharing.

Cancer Screenings: WHA covers all generally medically accepted cancer screening tests. This includes

- An annual cervical cancer screening test (including a conventional Pap smear test and a human papillomavirus screening test that is FDA approved;
- Upon referral by the Member's Physician, nurse practitioner, or certified nurse midwife, any cervical cancer screening test approved by the federal Food and Drug Administration;
- Screening or diagnostic mammography;
- 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 requirements that apply to Covered Services.

Clinical Trials: WHA covers routine patient care costs of clinical trials for Members for the prevention and detection of cancer or another life threatening condition, and for members who have been diagnosed with cancer or another life-threatening disease or condition. WHA only covers these services if the Member is eligible to participate according to the trial protocol, and either

- the Member's treating Physician has recommended participation, or
- the Member provided scientific information establishing that participation would be appropriate based on the Member being eligible to participate according to the trial protocol.

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

1. Drugs or devices associated with the clinical trial that are not FDA approved;
2. Services other than health care services, such as travel or housing expenses, companion expenses, and other non-clinical expenses that a

Member might incur as a result of participation in the clinical trial;

3. Any item or service provided solely for the purpose of data collection and analysis;
4. Health care services that are otherwise specifically excluded from coverage under the Member's plan.

Note: Some outpatient services require Prior Authorization. Some examples include diagnostic testing, X-rays, and surgical procedures. Please contact WHA's Member Services Department for more information.

Inpatient Services

WHA covers the following inpatient services:

- Semi-private room and board (private room covered if Medically Necessary);
- Physician's services including surgeons, anesthesiologists and medical consultants;
- Obstetrical care and delivery (including cesarean section). The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. **Note:** If you are discharged less than 48 hours, after a normal vaginal delivery or less than 96 hours after delivery by cesarean section, a follow-up visit for you and your newborn, within 48 hours of discharge is covered when prescribed by the treating Physician.
- Hospital specialty services including:
    - The use of the operating room and the recovery room,
    - Anesthesia,
    - Inpatient drugs,
    - X-ray,
    - Laboratory,
    - Radiation therapy,
    - Enteral formula for Members requiring tube feeding,
    - Nursery care for newborns.
- Medical, surgical and cardiac intensive care;
- Blood transfusion services;
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, if Medically Necessary and required incident to an admission for Covered Services;
- Respiratory therapy, cardiac therapy and pulmonary therapy, if Medically Necessary and required incident to an admission for Covered Services.

Inpatient hospitalization requires Prior Authorization, except in an Emergency. All inpatient hospitalizations, except for emergency episode of care, are subject to concurrent review. Concurrent review is a component of WHA's utilization management program to evaluate acute care needs of hospitalized patients, and to determine that services are medically necessary and provided in the appropriate setting and level of care. Concurrent review for acute hospitalizations may be conducted on a daily basis or as indicated by the member's condition and treatment of plan. Frequency of review is on a case-by-case basis.

Please refer to your Copayment Summary for copayment responsibility.

Note: Even if you stay in a hospital overnight, you might still be considered an outpatient. Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects which Copayments apply.

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.
- You are an outpatient if you doctor has not written an order to admit you to a hospital as an inpatient. This is considered "observation" and is an outpatient service. In these cases, you are considered an outpatient even if you spend the night at the hospital.

Mental Health and Substance Use Disorder Services

WHA has contracted with U.S. Behavioral Health Plan, California d/b/a OptumHealth Behavioral Solutions of California ("USBHPC") to manage all MHSUD benefits. If you need MHSUD treatment or have questions about your MHSUD benefits, please call USBHPC at 1.888.440.8225.

Mental Health Services

1. *Inpatient:* Inpatient Services are covered. This includes Inpatient psychiatric hospitalization, for the treatment of Mental Health Disorders/Conditions at a participating acute care facility, Residential Treatment Center or other inpatient facility. Inpatient services include psychiatric observation for an acute psychiatric crisis. Inpatient Services require Prior Authorization by USBHPC.
2. *Outpatient:* Members are entitled to receive care for Mental Health Disorders/Conditions by a Participating Provider. This care includes Medically Necessary clinical laboratory tests ordered by a Participating psychiatrist or attending physician.
    a. **Office visits** include, but are not limited to, mental health individual and group evaluation and therapy.
    b. **Outpatient other services** include intensive outpatient program, partial hospitalization/day treatment, outpatient electroconvulsive therapy, behavioral health treatment for autism, repetitive transcranial magnetic stimulation, psychological testing, and non-emergency psychiatric transportation.

Behavioral health treatment ("BHT") is also covered. BHT includes professional services and treatment programs, including applied behavior analysis ("ABA") and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Member with autism spectrum disorder ("ASD") and that meet all of the criteria in California Health and Safety Code §1374.73(c) (1).

BHT/ABA must be administered by:

- A qualified autism service provider, or
- A qualified autism service professional supervised by a qualified autism service provider, or
- A qualified autism service paraprofessional supervised by a qualified autism provider or qualified autism service professional.

Outpatient laboratory tests and X-rays are also covered when prescribed by a licensed psychologist to (i) diagnose and/or rule out an ASD condition or (ii) guide management of a medication for an ASD condition.

BHT/ABA requires prior authorization by USBHPC, and is subject to exclusions listed in Principal Exclusions and Limitations.

Note: Inpatient services, Office visits and Outpatient services are subject to the Copayment listed on your Copayment Summary.

Substance Use Disorder Services

1. *Inpatient:* Inpatient services for evaluation and care for substance use dependency are covered. This benefit includes detoxification services. Services require Prior Authorization by USBHPC and must be provided at a participating facility including Residential Treatment Center.
2. *Outpatient:* Outpatient services for evaluation and care for substance use dependency are covered and includes detoxification services, and must be provided by a Participating Provider.
    a. **Office visits** include, but are not limited to, substance use disorder individual and group counseling, medical treatment for withdrawal symptoms,and substance use disorder methadone maintenance treatment.
    b. **Outpatient other services** include psychological testing, intensive outpatient program, partial hospitalization/day treatment, office-based opioid treatment, and substance use disorder outpatient detoxification.

Residential recovery services are covered with Prior Authorization by USBHPC.

Methadone maintenance treatment is covered with Prior Authorization by USBHPC.

Note: Inpatient services, Office visits and Outpatient services are subject to the Copayment listed on your Copayment Summary.

Note: Even if you stay in a hospital overnight, you might still be considered an outpatient. Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects which Copayments apply.

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.
- You are an outpatient if your doctor has not written an order to admit you to a hospital as an inpatient. This is considered "observation" and is an outpatient service. In these cases, you are considered an outpatient even if you spend the night at the hospital.

Note: Medically necessary treatment of a MHSUD condition, including behavioral health crisis services provided to a member by a 988 center or mobile crisis team, is covered and does not require prior authorization.

Note: The Community Assistance, Recovery, and Empowerment (CARE) Court Program authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan to treat adults (those over 18 years of age) who are currently experiencing a severe mental illness and have a diagnosis within the schizophrenia spectrum or other psychotic disorders, who meets certain criteria. Health care services provided to a member pursuant to a court-approved CARE agreement or a CARE plan (which may include, but is not limited to, stabilization medication) is covered and does not require prior authorization (other than prescription drugs).

Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).

Prescription Medication Benefit

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

Prescription drugs prescribed by a Participating Provider and obtained at a Participating Pharmacy will be dispensed for up to a 30-day supply, except as set forth in the section below titled "Mail Order Prescriptions" or for contraceptives when allowed by law.

Copayments for covered medications are described in the Copayment Summary. Copayments will be prorated for partial fills of [Schedule II drugs] requested by the member or prescriber and received, as allowed by law.

Generic Medications are required. The pharmacist will automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication (Tier 2 or Tier 3) unless your physician writes "do not substitute" or "prescribe as written," there is not a Generic equivalent available, or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalence 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 at the number listed below. Regardless of Medical Necessity or Generic availability, you will be responsible for the Brand Name (Tier 2 or Tier 3) Copayment when a Brand Name Medication is dispensed. If a Generic Medication is available and you elect to receive a Brand Name Medication without medical indication from the prescribing Physician, you will be responsible for the difference in cost between Generic and Brand Name in addition to the copayment specified on your Copayment Summary. The amount paid for the difference in cost does not apply to the deductible or contribute to the

out-of-pocket maximum. In addition, if there is a maximum copayment applicable to prescription medications listed on your Copayment Summary, that limit does not apply when you elect to receive a Brand Name Medication without medical indication. See “Pharmacy Principal Exclusions and Limitations.”

Members will pay the lesser of their applicable copayment, the actual cost, or the retail price of the Prescription for both Participating Pharmacies and Mail-Order.

OptumRx’s Smart Fill program allows members to obtain less than a 30-day supply for a prorated Copayment. Only certain Specialty medications are available under the Smart Fill program. Medications obtained under the Smart Fill program may only be obtained at a pharmacy of a WHA-contracted hospital or medical group pharmacy or through Mail Order. To determine whether your prescribed medication is available under the Smart Fill program, call Member Services.

WHA may designate certain medications as “High-Value.” High-Value Medications may be Generic or Brand Name, and are medications that your Physician prescribes as an alternative to a higher cost medication. Copayments for High-Value Medications are waived. To determine whether your prescribed medication has an alternative High-Value Medication, call Member Services.

Note: Please follow the process outlined in the “Member Satisfaction Procedure” of this EOC for any inquiries, grievances or complaints regarding your Prescription Medication Benefits.

Preferred Drug List

WHA uses a Preferred Drug List and a Four-Tier Copayment Plan, rather than a closed formulary. The four tiers are: Tier 1, Tier 2, Tier 3 and Tier 4. Tier 4 Medications are only available through a pharmacy of a WHA contracted hospital or medical center or through Mail Order, except for Tier 4 Medications prescribed for the treatment of HIV, as explained below under “Mail Order Prescriptions, Tier 4 Medications.” See the section entitled “Tier 4-Specialty Medications.” Tier 1 Medications are covered at the lowest Copayment level. Tier 2 Medications are provided at the second Copayment level. Tier 3 Medications are covered at the third tier Copayment level. Tier 4 Medications are covered at a percentage copayment basis (refer to your Copayment Summary for details). There are a small number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the WHA Pharmacy and Therapeutics (P&T) Committee. Please note that a drug’s presence on the WHA PDL does not guarantee that the Member’s Physician will prescribe the drug. Members may request a copy of the PDL by calling the number listed below or view the document on our web site, westernhealth.com.

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

Mail Order Prescriptions – Maintenance Medications

Covered Prescription Medications that are to be taken beyond sixty (60) days are considered Maintenance Medications. Maintenance Medications are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions and diabetes. Up to a 90-day supply of Maintenance Medications may be obtained by mail order through OptumRx, WHA’s prescription benefit manager, or at CVS or Walgreens. Oral contraceptives are also available through the mail order program. You can request the order form and brochure for this benefit by contacting OptumRx Customer Service at 844.568.4150, 24 hours a day, 7 days a week (except Thanksgiving and Christmas) or online at westernhealth.com/pharmacy-information/.

Tier 4 Medications – Specialty Medications

Tier 4 Medications are only available through a pharmacy of a WHA contracted hospital or medical

center or through Mail Order, except for Tier 4 Medications prescribed for the treatment of HIV, which are available at any participating pharmacy. Tier 4 Medications may be obtained by mail order through OptumRx. You can order prescriptions online at westernhealth.com/pharmacy-information/, or by contacting OptumRx Customer Service at 844.568.4150. WHA may approve requests to fill Tier 4 Medication prescriptions at Participating Pharmacies in urgent situations. You may also obtain two initial fills for each prescription at any Participating Pharmacy. Note: The initial fills of certain medications may only be available through Mail Order.

- **Note:** Your right to purchase mail order medication may be suspended if there is an outstanding balance on your account.

Covered Prescription Medications

- Oral medications that require a Prescription by state or federal law, written by a Participating Physician, or pharmacist if allowed by law and dispensed by a Participating Pharmacy.
- Non-injectable specialty medication may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply (home self-injectable medications are covered under the medical plan).
- 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 OptumRx for reimbursement.
- Compounded Prescriptions for which there is no FDA approved alternative and which contain at least one prescription ingredient.
- Insulin and insulin syringes with needles, glucose test strips and tablets.
- Oral contraceptives and diaphragms.

Pharmacy Principal Exclusions and Limitations

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

1. Generic Medications are required. The pharmacist will automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication (when available) unless either of the following applies: 1) Your Physician writes "do not substitute" or "prescribe as written" on the prescription and signs it in accordance with California law. The Member must pay the Brand Copayment; or 2) there is not a Generic equivalent available, or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalence issues. In this case, the Brand Name Copayment will apply.
2. Some Prescription Medications may require Prior Authorization by WHA. For clarification, please contact WHA Member Services at the number listed below. Routine/non-urgent requests for Prior Authorization are processed within 72 hours if all applicable information is included with the request. Requests that are indicated as urgent/exigent will be reviewed within 24 hours. 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 within 72 hours for routine requests and 24 hours for urgent requests 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. Some Prescription Medications may require Step Therapy before they will be covered. Step Therapy requires a trial of one of more other Prescription Medications before the requested Prescription Medication will be covered. If it is

medically necessary for you to receive a Prescription Medication subject to Step Therapy *without* completing Step Therapy, you or your Physician may request an exception. You may contact Member Services or OptumRx Customer Service at 844.568.4150 for assistance with Step Therapy exceptions.

4. Covered Prescription Medications are limited to a thirty (30)-day supply at a Participating Pharmacy. Up to a ninety (90)-day supply of oral Maintenance Medications is available through WHA's Mail Order program (see above), or at CVS or Walgreens. Medications that cost over $600 for a thirty (30)-day supply are limited to a thirty (30)-day supply.
5. Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for contraceptives described under the heading "Family Planning," diabetes and pediatric asthma supplies as described under the headings "Diabetes supplies, equipment and services" and "Pediatric Asthma supplies, equipment, and services," folic acid, aspirin, and tobacco cessation products in certain circumstances, as explained in more detail in Appendix A.
6. Medications that are not Medically Necessary are excluded.
7. Treatment of impotence and/or sexual dysfunction must be Medically Necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to WHA for review. Drugs and medications are limited to eight (8) pills per thirty (30)-day period. All other limitations and exclusions will apply.
8. Medications that are experimental or investigational are excluded, except for Life-Threatening or Seriously Debilitating conditions and cancer clinical trials as described in this EOC/DF, under the section titled "Independent Medical Review of Experimental/Investigational Treatment."
9. There are a small number of drugs, regardless of PDL tier level, that may require Prior Authorization for a non-FDA-approved indication (off label use). For off label use, the medication must be FDA-approved for some indication and recognized by the American Hospital Formulary Service Drug Information or one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium or The Thomson Micromedex DrugDex, or at least two (2) 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. Drugs required for foreign travel are excluded, unless they are prior authorized for Medical Necessity.
11. Prescription products for cosmetic indications, including agents for wrinkles or hair growth or loss, and over-the-counter dietary/nutritional aids and health/beauty aids are excluded.
12. Drugs used for weight loss and/or dietary/nutritional aids which require a Prescription are excluded, unless they are prior authorized for Medical Necessity.
13. 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.
14. Medication for injection or implantation (except insulin and other medications as determined by WHA) is covered under the medical benefit as described in the EOC/DF under the sections titled "Outpatient Services" and "Diabetes supplies, equipment and services."
15. Pharmacies dispensing covered Prescription Medications to Members pursuant to an agreement with WHA or its pharmacy benefit manager and this pharmacy benefit, do so as independent contractors. WHA shall not be liable for any claim or demand on account of damages arising out of actions or omissions solely under the control and responsibility of the pharmacy

benefit manager and/or retail, specialty or mail order pharmacies. By way of example and not as an exclusive list, WHA shall not be liable for: errors or delays in dispensing of drugs or other prescription items, personal injuries occurring at pharmacies, and the like.

16. 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.
17. Medications for the treatment of Infertility are excluded.
18. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride) are excluded.
19. Medications for the treatment of short stature are excluded, unless Medically Necessary.
20. Replacement medications for drugs that are lost or stolen are not covered.

Submitting Prescription Claims for Reimbursement. If a Member pays for a covered Prescription Medication as described in this EOC/DF, the original receipt along with a copy of Member's identification card, address, a daytime telephone number, and the reason for the reimbursement request should be submitted to OptumRx within 60 days of purchase. No claim will be considered if submitted beyond twelve (12) months from the date of purchase.

Prescription claims under the Plan are processed by OptumRx. You can order claim forms online at westernhealth.com/pharmacy-information/ or by calling OptumRx Member Services at 844.568.4150.

You or your prescribing provider may request certain information regarding a prescription drug, including:

- Your eligibility for the prescription drug.
- The most current formulary or formularies.
- Cost-sharing information for the prescription drug and other formulary alternatives.
- Applicable utilization management requirements for the prescription drug and other formulary alternatives.

Other Health Services

Home Health Care Services are covered when prescribed by a Participating Provider and determined to be Medically Necessary. Home Health Care Services consist of part-time intermittent care provided at the Member's home in place of a continued acute hospitalization. Up to one hundred (100) visits per calendar year are covered. "Intermittent care" means no more than three visits per day.

Home Health Care Services are covered when arranged by a licensed Home Health Care agency and provided by one of the following professionals:

- a registered nurse,
- licensed vocational nurse,
- licensed home health aide,
- licensed public health nurse,
- licensed physical, occupational or speech therapist,
- social worker,
- respiratory therapist, or
- skilled pharmacy infusion therapist.

Each visit is limited to four hours per visit for home health aides and two hours per visit for all other professionals who may provide services under this benefit. Services provided by a licensed home health aide are only covered when provided under the direct supervision of another professional who may provide services under this benefit. This benefit does not include meals, housekeeping, childcare, personal comfort or convenience items, services or supplies, or full-time treatment of chronic conditions (Medically Necessary services provided for a chronic condition during a period of acuity are covered).

Hospice Care is covered when you have met the Hospice Care requirements services and supplies that would otherwise be provided for your illness.

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

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

Under Hospice Care, WHA covers the following services and supplies:

- participating Physician services;
- skilled nursing services;
- physical, occupational or respiratory therapy, or therapy for speech-language pathology;
- medical social services;
- home health aide and housekeeping services;
- palliative drugs prescribed for pain control and symptom management of the terminal illness in accordance with our drug formulary and Plan guidelines, obtained from a contracting Plan pharmacy;
- Durable Medical Equipment in accordance with Plan guidelines;
- short-term inpatient care including respite care, care for pain control and acute and chronic symptom management;
- counseling and bereavement services.

Skilled Nursing Facility care to a maximum of one hundred (100) days in each Benefit Period is covered if Medically Necessary. A Benefit Period begins on the date a Member is admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A Benefit Period ends on the date the Member has not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. This hundred (100) day maximum is a combined benefit maximum for all subacute stays.

Durable Medical Equipment (DME), Prosthetic Devices and Orthotic Devices are covered when Medically Necessary and prescribed by a Participating Provider Applicable Copayments are set forth in the Copayment Summary.

The DME benefit includes: canes, crutches, standard wheelchairs, oxygen and oxygen equipment. The orthotic devices benefit includes special footwear that is Medically Necessary as a result of foot disfigurement that arises out of cerebral palsy, arthritis, polio, spina bifida, diabetes and accidental or developmental disabilities. Please refer to the terms “Durable Medical Equipment,” “Orthotic Device,” and “Prosthetic Device” in the “Definitions” section for more information.

WHA will determine whether the covered device should be purchased or rented, and may directly order or coordinate the ordering of the covered device. Where two or more alternate covered devices are appropriate to treat the Member’s condition, the most cost-effective device will be covered. Coverage for devices is limited to the basic type of DME, Prosthetic Device or Orthotic Device that WHA determines to be necessary to provide for the Member’s medical needs

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.

Home hemodialysis and home peritoneal dialysis equipment and supplies are covered if the Member receives appropriate training at a dialysis facility designated by the Member’s Medical Group. Nonmedical items, such as generators, and comfort,

convenience, and luxury equipment are not included in this benefit.

The allowable cost of covered devices will not be applied toward similar services and supplies that are not covered devices.

Ostomy and Urological Supplies are covered, limited to the amount that meets the Member's medical needs.

Reconstructive Surgery is covered surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function; (B) to create a normal appearance, to the extent possible. Dental care that is integral to reconstructive surgery for cleft palate is covered.

Mastectomy and Reconstructive Breast Surgery to restore and achieve symmetry is covered. Coverage for a mastectomy includes coverage for all complications. This includes Medically Necessary physical therapy to treat the complications of mastectomy, including lymphedema; Prosthetic Devices and up to three brassieres required to hold a Prosthetic Device per year; or reconstruction of the breast on which the mastectomy is performed, including areola and nipple reconstruction, areola and nipple re-pigmentation, 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. Your attending Physician, will work with you to determine the length of the hospital stay for mastectomies and lymph node removals.

Fertility Preservation for Iatrogenic Infertility is covered for members undergoing a medically necessary treatment (such as chemotherapy, radiation treatment, or oophorectomy), that may directly or indirectly cause iatrogenic infertility. Fertility preservation services to treat iatrogenic infertility include, but are not limited to, the following procedures:

- Egg retrieval (including ovarian stimulation as needed) and storage of eggs or embryos for up to one year.
- Sperm collection and storage for up to one year.

Medications related to fertility preservation collection procedures are provided as described under the section entitled "Prescription Medication Benefit."

Please contact your treating physician for further information on covered fertility preservation services.

Note: This benefit covers fertility preservations services only, and do not include future implantation, or testing or treatment of infertility. See the section entitled "Principal Exclusions and Limitations" for infertility services exclusions.

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

Transplants are covered and ordered by a Participating Physician and approved by WHA's Medical Director in advance, subject to the terms of this EOC/DF. The transplant must be performed at a center specifically approved and designated by WHA to perform the requested procedures.

Coverage for a transplant includes coverage for the medical and surgical expenses of a live donor.

Diabetic supplies, equipment, and services for the treatment and/or control of diabetes are covered. Services include self-management training, education and medical nutrition therapy necessary to enable you to properly use prescribed equipment, supplies, and medications.

The following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin using diabetes, and gestational diabetes are also covered as Medically Necessary, even if the items are available without a Prescription:

- blood glucose monitors and blood glucose testing strips;
- blood glucose monitors designed to assist the visually impaired;
- insulin pumps and all related necessary supplies
- ketone urine testing strips;

- lancets and lancet puncture devices;
- pen delivery systems for the administration of insulin;
- podiatric devices (including footwear) to prevent or treat diabetes-related complications;
- insulin syringes;
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

The following items are covered and available under your Prescription Medication benefit:

- testing strips;
- lancets;
- insulin syringes.

Pediatric Asthma supplies, equipment, and services are covered when Medically Necessary for the management and treatment of pediatric asthma. This includes coverage for outpatient self-management training education to enable you to properly use the prescribed equipment, supplies and medications. The following equipment and supplies are covered for pediatric asthma, even if the items are available without a prescription:

- nebulizers, including face masks and tubing
- inhaler spacers
- peak flow meters

Acupuncture is covered when medically necessary and prescribed by a Participating Provider. Acupuncture benefits are provided through Landmark Health Plan of California. For full disclosure of benefits provided through Landmark Health Plan, please see the Landmark Schedule of Benefits or Evidence of Coverage available at lhp-ca.com or at mywha.org. For additional information, you may call Landmark's Customer Service Department at 800.638.4557, Monday through Friday, 8 a.m. to 5 p.m.

Note: Please follow the process outlined in the "Member Satisfaction Procedure" of this EOC for any inquiries, grievances or complaints regarding your acupuncture benefits.

Emergency medical transport services are covered when ordered by a Participating Provider and determined to be Medically Necessary. If you reasonably believe you are having an emergency, you should call "911." WHA covers ambulance services if you reasonably believe you are in an emergency situation.

Non-emergency medical transport services are covered inside the Service Area to transport a Member from the Member's residence to the location where a Covered Service will be provided, and from the location where a Covered Service is provided to the Member's residence, when the use of other means of transportation would endanger the Member's health and when ordered by a Participating Physician.

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

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

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

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

Nurse Advice Line (Fonemed). WHA contracts with Fonemedto provide around-the-clock nurse advice line services. Fonemed is staffed by registered nurses who are licensed in the State of California and have been trained in telephone triage and screening. Fonemed is available to you 24 hours a day, seven days a week by calling 888.656.3574. Fonemed is also available via "live chat" and "email messaging," which can be accessed at http://mywha.org/nurseadvice. Fonemed can help answer questions about a medical problem you may have, including:

- caring for minor injuries and illnesses;
- seeking the most appropriate help based on the medical concern, including help for MHSUD concerns;
- identifying and addressing emergency medical concerns, including help for MHSUD concerns;
- preparing for doctor visits;
- understanding prescription medications;
- helping with lifestyle choices to improve health;
- providing education and support regarding decisions about tests.

They can also help you get the appropriate care you need with the right WHA health care providers, including referrals to urgent care centers or hospital emergency rooms as necessary.

Note: Interpreter services are available. For relay assistance services, please call 888-563-2250 (Voice/TTY/ASCII) or 711 (TTY Operator Services).

Pediatric Dental services are covered through Delta Dental of California (Delta Dental). For full disclosure of benefit coverage, please see the Delta Dental EOC and benefit summary information included with this EOC/DF and/or available at westernhealth.com under Personal Access. For inquiries about benefits, covered services or providers, you may contact Delta Dental's Customer Service Department at 800.422.4324.

Pediatric Vision Services and Special Contact Lenses are covered as described below for Members until the end of the month in which the member turns 19 years of age.

Examinations are covered through your Medical Group. One comprehensive eye examination per year (including refraction, and dilation if medically indicated) is covered at no cost. Annual eye exams do not require a referral, but Members must select a Participating Provider. Certain vision exams may require a referral from your PCP.

Glasses, lenses, elective contact lenses and low vision devices are generally covered through EYEXAM, except as specifically noted below. The following are covered by EYEXAM at no cost:

- One pair of glasses with standard lenses (plastic, glass or polycarbonate); or
- One pair of standard hard or six pairs of standard soft contact lenses per calendar year instead of glasses
- One pair of Medically Necessary contact lenses (except as noted below).

Lenses covered at no cost include single vision, conventional bifocal, conventional trifocal or lenticular lenses as prescribed.

Medically Necessary contact lenses require prior authorization. Examinations are covered by your Medical Group. Once your Medical Group Participating Provider has determined you need Medically Necessary contact lenses, they will be covered by EYEXAM.

Expanded benefit for Aniridia and Aphakia: Up to two Medically Necessary contact lenses per eye are covered in any 12-month period to treat Aniridia. Up to six Medically Necessary contact lenses per eye are covered per calendar year to treat Aphakia including fitting and dispensing.

For children with low vision (defined as a significant loss of vision but not total blindness), one (1) pair of high-power spectacles per calendar year and a lifetime maximum of one (1) magnifier and one (1) telescope are covered at no charge, with prior authorization.

As described above, most glasses and contact lenses benefits and low vision devices are provided by EYEXAM. To obtain glasses, contacts, or low vision devices through EYEXAM under the pediatric vision benefits, you must obtain the eyewear from an EYEXAM Participating Provider. Please refer to mywha.org/directory or to a current EYEXAM Provider Directory. It is your responsibility to identify yourself or the Member as having an EYEXAM plan.

All claims for reimbursements for glasses or contacts must be submitted to EYEXAM within six months after date of service.

To obtain Medically Necessary contact lenses through your Medical Group as described above, you must obtain a referral from your Medical Group.

Please see your Copayment Summary for additional information.

Please contact EYEXAM's Customer Service Department at 844.844.0891 for inquiries about benefits, covered services or providers.

PRINCIPAL EXCLUSIONS AND LIMITATIONS

Lifetime and Annual Dollar Limits: There are no lifetime or annual dollar limits except where permitted by law. All dollar limits, if any, are specified in the Copayment Summary**.** WHA has no pre-existing condition exclusions for Member.

The following services and supplies are excluded or limited:

Exclusions

1. Any services or supplies obtained before the Member's effective date of coverage or after the Member's coverage has terminated.
2. Services and supplies which are not Medically Necessary. If a service is denied for lack of Medical Necessity, a Member may appeal the decision through the Independent Medical Review (IMR) process . See the section entitled "Independent Medical Review" under "Member Satisfaction Procedure" in this EOC/DF.
3. Services or supplies provided by a non-Participating Provider without written referral by the Member's PCP outside of an emergent situation. Care by non-Participating Providers will only be authorized and provided as a Covered Service if the care is determined to be Medically Necessary and not available through Participating Providers.
4. Any service provided with Prior Authorization if the service requires a PCP referral or Prior Authorization as explained in this EOC/DF or any rider.
5. Experimental medical or surgical procedures, services or supplies. Please refer to the section of this EOC/DF titled "Independent Medical Review of Experimental/Investigational Treatments" under "Member Satisfaction Procedure."
6. Long-term care benefits including skilled nursing care and respite care. Medically Necessary Covered Services described under the "Hospice Care" and "Skilled Nursing Facility" subheadings under the "Other Health Coverage" heading under the "Principal Benefits and Covered Services" section are covered.
7. Cosmetic services and supplies, except for Prosthetic Devices incident to a mastectomy or laryngectomy or reconstructive surgery, which is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease; to do either of the following: (A) to improve function; (B) to create a normal appearance, to the extent possible. The exclusion includes, but is not limited to, services and supplies performed in connection with treatment of hair loss, electrolysis, and chemical face peels or abrasions of the skin.
8. Non-emergent medical and psychiatric 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. (This exception does not include intraocular

lenses in connection with cataract removal), except for pediatric vision services as described under Other Health Services.

10. Hearing aids and batteries.
11. Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood and fertility preservation as required by law.
12. Dental care, except for the following:
    a. pediatric dental services as described under Other Health Services,
    b. non-dental surgical and hospitalization procedures required due to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate,
    c. when integral to reconstructive surgery for cleft palate or
    d. surgery or splints on the maxilla or mandible to correct temporomandibular joint disease (TMJ) or other medical conditions
    e. prescriptions written by a dentist as medically necessary.

    Covered Services must be Medically Necessary and Prior Authorized. Other Dental Services excluded include:

    a. Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth.
    b. Treatment of dental abscesses, braces, bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.
13. Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member.
14. Personal comfort or convenience items and home or automobile modifications or improvements. This includes, but is not limited to, televisions, radios, chair lifts, and 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. Immunizations required to obtain or maintain employment or participation in employee programs.
18. Housekeeping services except as listed under "Hospice Care;" meals or childcare.
19. Convalescent care and custodial care. This includes services that are non-nursing supervision of the patient. This exclusion does not apply to Covered Services included in the Hospice or Skilled Nursing benefits described under the "Principal Benefits and Covered Services" section of this EOC/DF, or unless Medically Necessary for mental health and substance use disorders.
20. Private Duty Nursing or shift care.
21. Non-prescription weight loss aids and programs.
22. Smoking cessation products and programs other than Medically Necessary Medications.
23. 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.
24. Food supplements or infant formulas, except in the treatment of PKU, or unless Medically Necessary for mental health and substance use disorders.
25. Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for:
    a. contraceptives described under the heading "Family Planning,"

b. diabetes and pediatric asthma supplies as described under the headings “Diabetes supplies, equipment and services” and “Pediatric Asthma supplies, equipment, and services,”

c. folic acid, aspirin, and tobacco cessation products in certain circumstances, as explained in more detail in Appendix A.

26. Services and supplies associated with the donation of organs when the recipient is not a Member of WHA.
27. Court-ordered health care services and supplies when not Medically Necessary.
28. Travel expenses, including room and board, even if the purpose is to obtain a Covered Service.
29. Expenses incurred obtaining copies of medical records.
30. Weight control surgery or procedures including without limitation gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction and HCG injections; and any Experimental Procedures for the treatment of obesity. However, Medically Necessary services as determined by WHA for the treatment of morbid obesity with Prior Authorization are covered.
31. Testing for the sole purpose of determining paternity.
32. Diagnosis and treatment for:
    a. personal growth and/or development,
    b. personality reorganization, unless Medically Necessary for mental health and substance use disorders or
    c. in conjunction with professional certification.
33. Educational Services including, but not limited to, for employment or professional purposes, unless Medically Necessary for mental health and substance use disorders.
34. Marriage counseling, except for the treatment of a Mental Health Disorder/Condition.
35. Psychological examination, testing or treatment for the following purposes:
    a. licensing; or
    b. insurance, judicial or administrative proceedings (including but not limited to parole or probation proceedings); or
    c. satisfying an employer's, prospective employer's or other party's requirements for obtaining employment.
36. Other psychological testing, except to diagnose and/or to guide treatment of a Mental Health/Substance Use Disorder.
37. Stress management therapy, unless Medically Necessary for mental health and substance use disorders.
38. Group homes (except Medically Necessary residential treatment prior authorized by USBHPC).
39. Wilderness programs, therapeutic boarding schools, and equestrian/hippotherapy, unless Medically Necessary for mental health and substance use disorders.
40. Dance therapy, recreation therapy, and activity therapy, such as music, dance, art or play therapies not for recreation, unless Medically Necessary for mental health and substance use disorders.
41. Hypnotherapy, unless Medically Necessary for mental health and substance use disorders.
42. BHT services for the purposes of providing respite, day care, or Educational Services, or to reimburse a parent for participating in the treatment.
43. Treatment of short stature unless treatment is Medically Necessary.
44. All services involved in surrogacy. This includes, but is not limited to, embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a surrogate arrangement. A surrogate pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the surrogate is a Member of WHA, she is entitled to maternity

services, but in the event pregnancy services are rendered to a woman in a surrogate arrangement, the Plan or its Medical Group has the right to impose a lien against any amount received by the surrogate/Member for reasonable costs incurred by WHA or its contracted Medical Groups.

45. Home birth delivery.
46. Services and supplies in connection with the reversal of voluntary sterilization.
47. Services related to assisted reproductive technology to treat infertility. This includes, but is not limited to:
    a. harvesting or stimulation of the human ovum,
    b. ovum transplants,
    c. Gamete Intrafallopian Transfer (GIFT),
    d. donor semen or eggs (and services related to their procurement and storage),
    e. artificial insemination, including related medications, laboratory, and radiology services,
    f. services or medications to treat low sperm count,
    g. In Vitro Fertilization (IVF),
    h. Zygote Intrafallopian Transfer (ZIFT), and
    i. preimplantation genetic screening.
48. Infertility services. This includes all services related to the diagnosis and treatment of infertility.
49. Chiropractic care, acupressure (unless provided under the acupuncture benefit).
50. Biofeedback, unless Medically necessary for mental health and substance use disorders.
51. Sex surrogacy services.
52. Eyeglasses cases.
53. Orthoptics or vision training.
54. Replacement lenses or frames for lenses or frames that are lost, stolen or broken, unless benefits are otherwise available.
55. Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Services), over the counter (OTC) hearing aids, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).

Limitations

The following limitations apply to Covered Services:

1. 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.
2. 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. WHA will not reimburse non-Participating Urgent Care facilities if the Urgent situation arose within WHA's Service Area.
3. Respiratory therapy, cardiac therapy and pulmonary therapy are limited to rehabilitative and habilitative services that are Medically Necessary and authorized in advance. Therapy and rehabilitation are not covered when:
    a. medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals; or
    b. a Member has already met the treatment plan goals.
4. Physical exams and/or laboratory, X-ray or other diagnostic tests ordered in conjunction with a physical exam are not covered if the purpose of the test is exclusively to fulfill an employment, licensing, sports, or school-related requirement.
5. If services or supplies are received while a Member is entitled to receive benefits from another health plan or collect damages due to a third party's liability, including Workers' Compensation, the Member is required to assist in the recovery of any WHA, USBHPC or

EYEXAM expense. WHA, USBHPC, EYEXAM and/or the Medical Group may file a lien on any proceeds received by a Member for any expense incurred by WHA, its Medical Group, USBHPC or EYEXAM, respectively. Members not legally required to be covered by Workers' Compensation benefits are eligible for twenty-four (24) hour coverage under WHA. See "Third Party Responsibility – Subrogation."

6. WHA is not liable for the lack of available services in the event of a major disaster, epidemic, war, riot or other like circumstance beyond the control of WHA which renders a Participating Provider unable to provide services. However, Participating Providers will 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.
7. For Covered Services, WHA reserves the right to coordinate your care in a cost-effective and efficient manner.
8. Private hospital rooms are not covered unless Medically Necessary and authorized by WHA.
9. Diagnostic procedures or testing for genetic disorders is limited to those that are not considered experimental or investigational, are medically necessary and the outcome of which will affect the medical treatment plan.

BECOMING AND REMAINING A MEMBER OF WHA

Eligibility and Application for Coverage

Eligibility requirements and enrollment dates for your participation in WHA's health coverage are set by Covered California in accordance with state and federal law. You and your eligible Family Members apply for membership through Covered California or WHA. The date on which you become eligible to enroll is established by Covered California.

The eligibility rules shown in this section are WHA's eligibility rules for you and your dependents. Subscribers and dependents must also meet Covered California's requirements.

These rules apply at the time of enrollment and throughout your membership in WHA.

Subscribers

To be eligible as a Subscriber, you must:

1. Enroll during an Open Enrollment Period or a Special Enrollment Period as permitted under state law and regulations; and
2. Live within the WHA Service Area.

Service Area Requirement

Except as described below, all Subscribers and dependents must live within the WHA Service Area code (see map and list of zip codes on the first page), meaning that the Primary Residence is within the WHA Service Area. If a Subscriber or dependent no longer lives in the WHA Service Area, they are no longer eligible for coverage.

Living outside the WHA Service Area is a material fact that must be reported to WHA by the Subscriber or Member. Regardless of when WHA is notified, the Member's eligibility for coverage ends immediately if the residence is not within the Service Area. **Note:** WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Eligible Dependents ("Family Members") and Age Limits

Eligible Family Members include:

- Your legal spouse or adult registered domestic partner (see below for details). (The term "spouse" used in this EOC/DF includes your adult registered domestic partner as defined below.)

- Your parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the WHA Service Area.
- Your and your spouse's children under the age of twenty-six (26), including natural children, stepchildren, legally adopted children, children under legal guardianship of the Subscriber and the Subscriber's spouse, and children for whom the Subscriber has assumed a parent-child relationship, as certified by the Subscriber ("Child[ren]").

  Note: An enrolled Child may remain enrolled until the end of the calendar year in which he or she reaches age 26. The Child's coverage will end on the last day of the calendar year during which the Child becomes ineligible.

A Child may enroll even if:

1. The Child was born out of wedlock.
2. The Child is not claimed as a dependent on the parent's federal income tax return.
3. The Child does not reside with the parent or is married. **Note:** The Child must live within WHA's Service Area, unless coverage for the Child is mandated by a qualified medical support order. Eligibility for children residing outside the Service Area does not relieve the Child from the requirement that all Covered Services must be obtained from WHA's network of Participating Providers, except in an Emergency Care situation or an Urgent Care situation where the Child receives services from an Urgent Care facility outside WHA's Service Area.
4. The Child does not reside within WHA's Service Area, but only if one of the following apply:
   a. The Subscriber or other eligible dependent parent is subject to a qualified medical support order requiring the parent to provide coverage for the Child; or
   b. The Child is a full-time student at an accredited post-secondary institution. Student verification is required. Full-time means the student is taking at least nine (9) semester units (or equivalent hours) at an accredited college, university or vocational school. Breaks in the school calendar do not disqualify the Child from coverage as a full-time student.

   For medical leaves of absence from full-time student status, the Child may be eligible for continued coverage under the paragraph entitled "Physically or mentally disabled" later in this section. If the nature of the Child's injury, illness or condition does not make the Child eligible for continued coverage as described in the paragraph entitled "Physically or mentally disabled," the Child's coverage will not terminate for a period not to exceed twelve (12) months or until the date on which the coverage is scheduled to terminate pursuant to the Group Service Agreement and this EOC/DF, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the Physician determines the illness prevented the Child from attending school, whichever comes first.

   Note: Documentation or certification of the Medical Necessity for a leave of absence from school must be submitted to WHA at least thirty (30) days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or thirty (30) days after the start date of the medical leave of absence from school.

- Physically or mentally disabled, unmarried dependent children over age twenty-six (26) who are incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition incurred prior to age twenty-six (26), and who are dependent upon you for support. WHA will send you a notice that a covered dependent child will be terminated at least ninety (90) days in advance of the covered dependent child's twenty-sixth (26th) birthday. If the covered dependent child qualifies as set forth in this paragraph, the Subscriber must submit written proof of the disability and certification of the dependent child's dependence upon the

Subscriber for support within sixty (60) days of the date you receive the notice. WHA will determine whether the child meets the requirements in this section before the child's twenty-sixth (26th) birthday. If the child does meet the requirements, after two (2) years WHA may request proof each year.

Note: Eligibility for children residing outside the Service Area does not relieve the Child from the requirement that all Covered Services must be obtained from WHA's network of Participating Providers. Children are exempt from this requirement in an Emergency Care situation or an Urgent Care situation where the Child receives services from an Urgent Care facility outside WHA's Service Area. Please see "Choice of Physicians and Other Providers" for more information.

Adult Registered Domestic Partners

All benefits described in this EOC/DF apply to the Registered Domestic Partner of a Subscriber to the same extent and subject to the same terms and conditions as they apply to a spouse of the employee or Subscriber. "Registered Domestic Partner" is defined as in Section 297 of the Family Code and is summarized below.

1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
2. A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
    a. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
    b. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
    c. Both persons are at least 18 years of age, except as provided in Section 297.1.
    d. Both persons are capable of consenting to the domestic partnership.

Ineligibility

If you were previously a Member of WHA and your coverage was cancelled for any of the reasons listed under "Termination for Fraud or Misrepresentation" you are not eligible to enroll. Grandchildren born to a covered dependent Child are ineligible for coverage.

Effective Date of Coverage

Your effective date of health coverage is as follows:

- If you are newly eligible to enroll, coverage begins on the first day of the month following the month in which you meet eligibility requirements and enroll in the Plan.
- Your or your spouse's newborn Child is temporarily covered for thirty (30) days from the date of birth. If the mother is a WHA Member, the newborn Child must obtain services from providers within the mother's Medical Group during the first thirty (30) days following the date of birth. To continue coverage beyond this initial period, the Child must be enrolled with WHA no later than the sixtieth (60th) day after the Child's birth date. If the newborn Child remains hospitalized longer than thirty (30) days following the date of birth, the newborn Child must continue to obtain services from providers within the mother's Medical Group until the 1st of the month following discharge. Your spouse, if not previously enrolled in the Plan, may enroll at the same time as the newborn Child if your spouse meets all eligibility requirements.
- For children adopted after you have enrolled, WHA must receive notification to enroll the Child along with documentation within sixty (60) days of the date adoptive custody starts. Coverage begins on the date adoptive custody starts.
- Coverage for other Family Members who become eligible after you have enrolled (i.e., through marriage) begins on the first of the month following the date of the qualifying event. WHA

must receive notification within sixty (60) days of eligibility.

Open Enrollment

Open Enrollment is held once a year. These dates are set by federal and state law and subject to change, and includes special enrollment periods in addition to the “Special Enrollment” section described below . Coverage begins January 1 for individuals enrolled during Open Enrollment. If you fail to enroll during an Open Enrollment Period or as otherwise explained in this section, you must wait until the next Open Enrollment Period.

Special Enrollment

If you fail to enroll during an Open Enrollment Period, you must wait until the next Open Enrollment Period to enroll, unless one of the following applies and you apply for enrollment either sixty (60) days before or sixty (60) days after the applicable event:

1. All of the following:

   You were or your eligible dependent was covered under another employer health benefit plan, COBRA continuation coverage, Medicare, Medi-Cal or another government-sponsored program providing health benefits when initially eligible to enroll in this health plan;

   You have or your eligible dependent has lost or will lose Minimum Essential Coverage under another employer health benefit plan as a result of termination of employment, change in employment status, termination of the other plan’s coverage, the death of or divorce or legal separation from the person through whom you were or your eligible was covered as a dependent, exhaustion of COBRA continuation coverage, loss of Medicare, Medi-Cal, or other government-sponsored coverage; and,

   You request or your eligible dependent requests enrollment in this health plan within thirty (30) days after termination of coverage or cessation of employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within sixty (60) days after termination of Medicare, Medi-Cal, or other government-sponsored coverage.

2. You gain a dependent. Both you and the dependent are eligible to enroll. For more information, see “Effective Date of Coverage” earlier in this section.
3. A court has ordered coverage for your spouse or minor child.
4. You or your eligible dependent are enrolled with a carrier that substantially violated a material provision of its contract with you, as determined by Covered California.
5. You or your eligible dependent moved outside the service area of your existing carrier.
6. You are newly eligible or ineligible for Advance Payments of Premium Tax Credit under federal law, or are newly eligible or ineligible for cost-sharing reduction as determined by Covered California.
7. You or your eligible dependent are an Indian, as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638), and have not changed health plans in the last month (Indians may change plans monthly).
8. You or your eligible dependent gained access to new health benefit plans as a result of a permanent move.
9. You or your eligible dependent were released from incarceration.
10. You or your eligible dependent are a member of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.
11. You or your eligible dependent demonstrate to Covered California, with respect to health benefit plans offered through Covered California, that you or your eligible dependent did not enroll in a health benefit plan during the last available Open Enrollment Period because you were misinformed that you or your eligible dependent

were covered under Minimum Essential Coverage.

12. You or your eligible dependent are receiving the services described under Continuity of Care in this EOC/DF from another health care plan and the provider of those services is terminated from or otherwise ceases participation in that plan.
13. You or your eligible dependent qualify for an exceptional circumstance as established by Covered California.
14. You or your eligible dependent gained citizenship, became a national or otherwise became lawfully present.
15. Your nonenrollment, or the nonenrollment of your eligible dependent is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of Covered California or the California Health and Human Services Agency as determined by Covered California.

    The effective date of coverage for late enrollment under this section will be determined by Covered California in accordance with state and federal law.

Loss of Eligibility and Redetermination of Eligibility

WHA must be notified immediately by the Subscriber or Member if the Subscriber or any Family Member(s) cease to meet eligibility requirements. If you do not notify WHA and WHA becomes aware of this information, your coverage will end on the date the loss of eligibility occurred.

For more information, see “Termination Due to Loss of Eligibility” below.

In addition to termination for loss of eligibility as described above:

Your spouse loses eligibility to continue coverage as a dependent if:

- You divorce, or you become legally separated.

Your children lose eligibility to continue coverage as dependents if they:

- Reach the age limits for continuing coverage or cease to meet other eligibility requirements for dependency status.

Loss of Eligibility for Cost-Sharing Reduction

Covered California will verify, at least annually, that Members enrolled in plans that provide a cost-sharing reduction based on income level are still eligible for those plans. If you are enrolled in a plan providing cost-sharing reduction and later lose your eligibility for that plan, Covered California will notify you. Your last day of coverage will be the last day of the month following the month in which Covered California sends you this notice.

Termination Due to Loss of Eligibility

If you met the eligibility requirements in this EOC/DF on the first day of a month, but later in that month you no longer met those eligibility requirements, your membership terminates on the first day of the following month at midnight.

Termination for Fraud or Misrepresentation

WHA may terminate your membership if you commit fraud or intentional misrepresentation of a material fact related to your eligibility or receipt of health care services or the receipt of health care services by another. If WHA demonstrates fraud or an intentional misrepresentation of a material fact, your contract with WHA may be subject to rescission (see below). Examples of actions that may lead to termination include, but are not limited to:

- You seek and/or obtain medications under false pretenses to support a drug dependency or for the illegal sale of medications.
- You obtain or attempt to obtain Covered Services by means of fraud or intentional material misrepresentations.
- You permit any other person to use a Member’s identification card to obtain services or otherwise

employ deception in the use of your identification card, or you engage in any fraudulent conduct.

- You intentionally mislead WHA about whether you live in the Service Area.

Rescission

WHA may rescind its contract with you if you commit fraud or intentionally misrepresent a material fact. Rescission means a termination of your membership that is retroactive back to the date of enrollment. Examples of material facts include, but may not be limited to:

- Information including, but not limited to, residence address, age and gender provided during the enrollment process.
- Information about your eligibility for WHA coverage.

WHA will not rescind its contract with you after the first twenty-four (24) months of your coverage. Your membership may still be terminated after twenty-four (24) months as explained in this section.

WHA will send you a notice explaining the reasons for the intended rescission and your rights to appeal a rescission to WHA and to the Department of Managed Health Care. WHA will send this notice at least thirty (30) days in advance of implementing the rescission.

Termination for Discontinuance of a Product or Decertification by Covered California

WHA may terminate your membership if the health plan described in this Agreement is discontinued or if the health plan described in this Agreement is terminated from or decertified by Covered California, as permitted or required by law. If WHA continues to offer other individual products, we may terminate your membership under this product by sending you written notice at least ninety (90) days before the termination date. WHA will make available to you all health benefit plans that it makes available to new individuals. If WHA ceases to offer all health care plans in the individual market, WHA may terminate your membership by sending you written notice at least one hundred eighty (180) days before the termination date.

Renewal Provisions

Annual renewal is automatic provided that 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. If your Premiums have not been properly paid, but 30 days have not elapsed since you were given the notice described under "Termination for Nonpayment," your coverage will be automatically renewed.

Member-Initiated Termination

You may terminate your membership at any time. Once terminated, you may only reenroll during Open Enrollment or if a Special Enrollment event occurs, as explained under "Open Enrollment." Termination will be effective no later than 14 days after the day WHA or Covered California receives your request.

Termination for Nonpayment

WHA may terminate your coverage for failure to pay premiums, following a 30-day grace period. You will receive a Notice of Start of Grace Period after your last date of paid coverage. If your premium remains unpaid at the end of the grace period, your coverage will terminate and you will receive a Notice of End of Coverage. If you receive advance payments of an applicable premium tax credit and your coverage is terminated under this section, you will have the right to retroactively reinstate your coverage back to the last day of paid coverage if all past due premiums are paid within 60 days of termination of your coverage.

Effective Date of Termination of Coverage

Coverage ends as explained below:

- At midnight on the first day of the month following the last month in which you were eligible and for which you have paid premium.

- At midnight on the termination date specified in the section “Termination of Benefits, Fraud and Exception to Cancellation,” “Termination.”
- At midnight on the date you request, if your termination request is received by WHA at least 14 days in advance of the requested effective date. If your request is not received within 14 days of your requested effective date, termination will be effective 14 days after WHA receives your request, or on an earlier date mutually agreed upon by you and WHA.

Refunds

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

FINANCIAL CONSIDERATIONS

Prepayment Fees

You are responsible for prepayment of monthly Premiums for WHA coverage by the first business day of each month. 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, unless you are within a 30-day grace period as set forth under the section “Termination for Nonpayment.”

Changes in Rates/Benefits

Premium rates and Covered Services may be changed by WHA, to the extent permitted by law, during the term of the agreement. WHA will notify you in writing sixty (60) days before any change in rates or benefits becomes effective.

Other Charges

Copayments

You are responsible for fees (Copayments) paid to providers at the time the service is rendered. For some Covered Services, you pay the Copayment until your annual out-of-pocket maximum is reached. For services that are subject to the Deductible, you pay the Copayment only after the Deductible is met. See the “Liability of Member for Payment” section under the “Introduction” to this EOC/DF for more information. Also see the Copayment Summary for specified Copayments.

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

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

Some offices may charge you a fee to provide copies of your medical records.

Deductibles

If you have a medical Deductible listed on your Copayment Summary, you must meet a Deductible each calendar year. See your Copayment Summary for an explanation of individual and family amounts. The only payments that count toward a Deductible are those you make for Covered Services that are subject to the Deductible. These must be paid to providers when billed or at the time the service is rendered.

Also, if you have a prescription Deductible listed on your Copayment Summary, in any calendar year, you must pay the full Contracted Rate as described on your Copayment Summary until you meet the prescription Deductible during that calendar year.

“Preventive Care Services” are never subject to a Deductible.

If you have both a medical Deductible and a prescription Deductible, the medical Deductible and the prescription Deductible must each be met separately. The only payments that count toward the

Deductible are those you make for Covered Services that are subject to the Deductible.

The Deductible does not apply to any payments made for benefits purchased separately as a rider, including but not limited to infertility benefits. Any payments for non-Covered Services do not count towards either Deductible.

If you have a Deductible, you will be charged or billed by the provider for the full Contracted Rate for each rendered Covered Service. Once the total of the claims we have applied to the Deductible reaches your annual Deductible amount, you will no longer be required to pay the Contracted Rate. Instead, you will pay only your Copayment, or nothing if your plan does not have a Copayment after the Deductible.

Example:
$2,800 Deductible, $40 Copayment

On January 2, you visit a provider and receive services. The Contracted Rate for this visit is $100. You will pay the provider the full $100. Over the next several months, you continue to pay the Contracted Rate for Covered Services received during additional appointments, for a total of $2700. You have now reached your Deductible amount of $2800. At your next office visit and every office visit until December 31, or the date you reach your out-of-pocket maximum, you will pay $40, regardless of the Contracted Rate for the visit.

Your Copayment Summary details which Covered Services are subject to the Deductible. A complete list of preventive care services that are not subject to the Deductible is in Appendix A.

Deductible plans are complex plans that may result in significant out-of-pocket costs to you. Please be sure you understand these costs prior to receiving services. You may contact Member Services for additional information on your Deductible plan.

Please refer to the Copayment Summary to learn if there are Deductibles on your plan and, if so, which Covered Services are subject to a Deductible.

Most providers will bill you for charges, while some may ask that you pay for services at the time you receive them. If your provider bills you for charges, before paying you should verify that the provider has first submitted the bill to WHA. This will ensure that you are billed the correct amount and that your Deductible is accurately tracked. You can do this by logging into the WHA website (westernhealth.com) and following the “Eligibility Information” link to view claims that have been submitted to WHA.

Copayments and Deductibles for Newborns

Copayments and Deductibles are incurred by newborn Children, whether or not the newborn Child is enrolled in the Plan and which are in addition to the cost-sharing due for services provided to the member giving birth.

Copayments and Deductibles for Telehealth Services

To the extent services are provided by telehealth, the cost sharing will be the same or lower than an in person visit.

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 and/or Deductibles. **Whether provided by Participating or non-Participating Providers, WHA covers your emergency services, including air-ambulance services; and your only liability is the applicable copayment and/or deductible.** Requests 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 the number listed below to find out where and how to submit it.

If you receive services from a Participating hospital or other facility, the cost sharing you pay for services will not exceed the amounts listed on your Copayment Summary, even if the services were provided by a Non-participating provider.

Non-participating hospitals and Physicians are prohibited under state law from billing you more than your applicable copayment and/or deductible for

emergency services. When you receive emergency services from a non-participating hospital or Physician, WHA will receive a bill and will pay the reasonable and customary value for the services, as required by law. Regardless of the amount of the total billed charges, you are never responsible for more than your applicable copayment and/or deductible for hospital or physician services provided in an emergency. If you were billed more than your applicable copayment and/or deductible for emergency services provided by a non-participating hospital or Physician, you may report the provider to the California Department of Managed Health Care by calling 888.466.2219. You may also contact Member Services at the number listed below for assistance.

Cost Sharing for American Indians and Alaska Natives

American Indians or Alaska Natives will have zero cost sharing for medical and prescription services received directly from the Indian Health Service, an Indian Tribe, Tribal Organization or through a referral under Contract Health Services, but are subject to the regular cost sharing requirements of the plan if they receive services from WHA's network providers. American Indian or Alaska Native members who meet certain income level requirements may be eligible to enroll in a zero cost share plan, which allows those members to access services with zero cost sharing from WHA's network providers. Eligibility for this plan is determined by Covered California in accordance with state and federal law.

Out-of-Pocket Maximum Liability

The annual out-of-pocket maximum liability (OOP) for Covered Services is described in your Copayment Summary. Please refer to your Copayment Summary to determine your plan's OOP amount for the individual Member (one amount) and for the Subscriber and all of his or her Family Members (a different amount).

The Copayments and Deductibles you pay during the calendar year (including medical, pharmacy, dental and **MHSUD**) will be applied to the OOP, except as described below. When you pay a Copayment or Deductible 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 additional Copayments or Deductibles for Covered Services through the end of the calendar year.

If you have paid more than your OOP during any calendar year, WHA will send you a refund if you request it by the end of the calendar year following the year in which you have paid more than your OOP.

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

- Any payments for any benefits purchased separately as a rider, including but not limited to infertility benefits.

It is recommended that Members keep all Copayment receipts in case they are needed as verification that the OOP has been reached for that calendar year.

WHA will notify you of your accrual balance towards your annual deductible and/or OOP max for every month in which benefits were used and until the accrual balance equals the full deductible and/or OOP max amount. A notice will be mailed to you unless we have an email address on file. You can access your most up-to-date accrual information at any time by:

- Contacting WHA Member Services to obtain this information over the phone, or to request the information be sent to you via mail or email.
- Logging in to your mywha.org account.

If you no longer wish to receive mailed notices, you may opt out. Please contact Member Services or log into your mywha.org account to update your accrual notice preferences.

For Members on high-deductible health plans, when you have reached the OOP, WHA will automatically provide you with a document that shows you do not have to pay any additional Copayments or Deductibles for Covered Services through the end of the calendar year.

Your accrual balance will not reflect any claims for services that have not been submitted by the provider and processed by the Plan.

Coordination of Benefits

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

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

Definitions

"Primary Plan" means the plan whose coverage is primary to other Insurers and should pay first, up to its limits. If any covered expenses remain after the Primary Plan has paid, those would be paid by a "Secondary Plan" if they are covered services under the Secondary Plan.

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

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

1. Plan Without COB Provision is Primary Plan

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

2. Plan Covering Patient as an Active or Retired Employee is the Primary Plan

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

3. When the Patient is a Dependent Child With Both Plans, the Birthday Rule Applies

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

4. How Primary Plan for Divorced or Legally Separated Spouses is Determined

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

   b. If there is no court decree regarding health care responsibility, the plan of the parent with custody is the Primary Plan.

5. Unmarried Spouses With Legal Custody

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

6. Remarried Spouses

   In the case of a divorced parent, when the court has not assigned financial responsibility for the child's medical, dental or other health care expenses, and the parent has remarried, the plan

who covers the child as the dependent of the parent with custody is the Primary Plan, and the stepparent's plan is the Secondary Plan. The plan of the parent without custody is tertiary. If the parent with custody does not have his or her own health coverage, the stepparent's plan is then the Primary Plan and the plan of the parent without custody becomes the Secondary Plan.

7. When the Court Orders Joint Custody

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

8. Retired and Laid-off Employees

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

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

Rules for Coordination with Medicare Coverage

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

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

1. Working Aged

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

   a. An age 65 or over working individual who:

      i. Works for an employer that employs 20 or more employees, and

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

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

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

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

      ii. Entitled to Part A & B.

2. Retiree

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

3. End Stage Renal Disease/Permanent Kidney Failure

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

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

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

4. Disability

   a. A WHA commercial plan is primary for Members under the age of 65 who have Medicare because of a disability and who are

covered under a Large Group Health Plan (LGHP) through their current employment or through the current employment of any family member. An LGHP is an employer which employs at least 100 employees.

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

Coordination of Dental Benefits

Delta Dental is the primary plan for pediatric dental services.

Other COB Rules

1. Duplicate Coverage

    a. If a Member is covered by more than one WHA commercial group plan, WHA will use the COB rules under "Rules When There is More Than One Commercial (Non-Medicare) Plan" to determine which plan is primary. Members covered by more than one WHA plan who are not enrolled with the same PCP for both plans will not benefit from lower cost-sharing that would otherwise occur as a result of being enrolled in multiple plans.

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

2. Pharmacy Benefits

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

3. Disagreements With Other Insurers

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

Third Party Responsibility – Subrogation

If a Member suffers injury, illness or death due to the act or omission of another person (a "third party"), WHA will, with respect to services provided in connection with that injury, pay for and/or provide Covered Services, but will retain the right to seek restuitution, reimbursement or any other available remedy in order to recover the amount paid and/or the value provided. By enrolling in this Plan, each Member grants WHA and each Contracted Medical Group and Participating Hospital a lien and right of reimbursement on any Recovery received by the Member or Representative due to the act of omission of a third-party 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 shall execute and deliver to WHA or its Recovery Agent any and all requested questionnaires, authorizations, assignments, releases, reports or other documents requested which may be needed to fully and completely protect the legal rights of WHA;

2. Immediately following the initiation of any injury, illness or death claim, the Member or his or her Representative shall provide the following information to WHA's Recovery Agent in writing: the name and address of the third party; the name of any involved attorneys; a description of any potentially applicable insurance policies; the

name and telephone number of any adjusters; the circumstances which caused the injury, illness or death; and copies of any pertinent reports or related documents;

3. Immediately upon receiving any Recovery, the Member or Representative shall notify WHA's Recovery Agent and shall reimburse WHA for the value of the services and benefits provided, as set forth below. Any such Recovery by or on behalf of the Member and/or Representative will be held in trust for the benefit of WHA and will not be used or disbursed for any other purpose without WHA's express prior written consent. If the Member and/or Representative 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" means Western Health Advantage, Participating Hospitals or Physicians providing Covered Services and/or their designees.

"Recovery" means compensation received from a judgment, decision, award, insurance payment or settlement in connection with anyclaim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third party, including uninsured and underinsured motorist claims, medical payment benefits and no-fault insurance.

"Recovery Agent" means the law firm of Tennant & Ingram as follows:

WHA TPL
c/o Tennant & Ingram
2101 W Street
Sacramento, CA 95818
916.244.3400
916.244.3440 fax

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

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

The amount WHA is entitled to recover for capitated and/or noncapitated Covered Services pursuant to its reimbursement rights described in this EOC/DF is determined in accordance with California Civil Code Section 3040. This calculation 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. Reimbursement related to worker's compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by Civil Code Section 3040 will be determined in accordance with the provisions of this EOC/DF and applicable law.

Under certain circumstances, the benefits available to the Member in conjunction with an injury, illness or death may invoke other available insurance coverages, such as automobile and premises medical payment benefits, no fault insurance or workers' compensation benefits. In those instances, WHA's obligation to pay for and/or provide Covered Services shall be secondary to the other available insurance benefits and policies.

Other Limitations on Coverage

Limitations on your coverage may apply in the event of major disasters, epidemics, labor disputes and other circumstances beyond WHA's control.

MEMBER SATISFACTION PROCEDURE

Benefit Questions and Clarifications

WHA strives to provide exceptional health care services to you. If you have a concern about your medical care, you should discuss it with your PCP. If you need help answering your questions or clarifying procedures, call Member Services toll-free at 888.563.2250 between 8 a.m. and 6 p.m. Monday through Friday or visit or write to:

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

A Member Services representative will research and respond to your questions. If you are not satisfied with the response or action taken, you may submit an Appeal or Grievance (see "Appeal and Grievance Procedure" below).

Information and Assistance in Other Languages

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

Appeal and Grievance Procedure

If you have a Complaint with regard to WHA's failure to authorize, provide or pay for a service that you believe is covered, a cancellation, termination, non-renewal or rescission of your membership or any other Complaint, please call Member Services toll-free at 888.563.2250 for assistance. If your Complaint is not resolved to your satisfaction after working with a Member Services representative, your may submit a verbal or written Appeal or Grievance. A written Appeal or Grievance may be submitted to:

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

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

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the Appeal is being decided.

If you believe that your membership has been or will be improperly canceled, rescinded or not renewed, you have the right to file a grievance with WHA, which will be considered urgent and processed as an expedited review; or you have the right to file a grievance with the Department of Managed Health Care. If your coverage is still in effect when you submit your Grievance to WHA, your coverage will be continued while your Grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the Grievance, including any appeal to the California Department of Managed Health Care (see below), if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All Premiums must be paid timely.

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

A Grievance Form and a description of the Grievance procedures are available at every Medical Group and

Plan facility and on WHA's web site. In addition, a Grievance Form will be promptly sent to you if you request one by calling Member Services. If you would like assistance in filing a Grievance or an Appeal, please call Member Services and a representative will assist you in completing the Grievance Form or explain how to write your letter. We will also be happy to take the information over the phone verbally.

It is the policy of WHA to resolve all Appeals and Grievances within thirty (30) days of receipt. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the Grievance or Appeal will be sent to the Member and will include an explanation of the contractual or clinical rationale for the decision. Contact Member Services for more detailed information about the Appeal and Grievance procedure.

Department of Managed Health Care Information

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.888.563.2250 or 711 for TTY** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for 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 **(1.888.466.2219)** and a **TDD line (1.877.688.9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.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 Pediatric Dental Benefits

If you have a complaint or grievance regarding your benefits, complaint forms may be obtained from Delta Dental, WHA, the subscriber group, participating provider's office, Delta Dental website atwww.deltadentalins.com, and/or requested by calling Customer Service at 800.765.6003. Grievances can be submitted to:

DeltaCare Quality Management
P.O. Box 6050
Artesia, CA 90703

Grievances Related to Pediatric Vision Benefits

If you have a complaint or grievance regarding your pediatric vision benefits relating to eye exams or vision prescriptions, contact WHA Member Services toll-free at 888.563.2250 or you can submit a complaint or grievance to:

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

If you have a complaint or grievance regarding your vision materials benefits (such as eyeglasses or contacts), complaint forms may be obtained from EYEXAM, WHA, the subscriber group, participating provider's office, by visiting mywha.org/grievance,

and/or requested by calling EYEXAM's Customer Service at 844.844.0891. Grievances can be submitted to:

EYEXAM
Attn: Quality Assurance
4000 Luxottica Place
Mason, OH 45040

Or Fax: 1.513.492.3259

Grievances Related to Mental Health and Substance Use Disorder Benefits

USBHPC administers all levels of review under WHA's Grievance Process for Complaints regarding MHSUD Services. If you have an inquiry or concern regarding your MHSUD benefits, you should first call USBHPC's Customer Service Department at 1.800.765.6820.

Every effort will be made to resolve your inquiry or concern informally through the Customer Service Department. If you are not satisfied with this resolution, you may submit a formal verbal or written Grievance to USBHPC's Grievance Unit at:

U.S. Behavioral Health Plan, California
Attn: Grievances and Appeals
P.O. Box 30512
Salt Lake City, UT 84130

Or

425 Market Street, 14th Floor
San Francisco, CA 94105

Fax: 855.312.1470
Telephone: 800.985.2410
TDD Line: 711

Or at the USBHPC Web Site:
www.liveandworkwell.com

A Grievance form and a description of the Grievance procedures are available at every USBHPC Participating Provider office and USBHPC facility, and on USBHPC's web site. In addition, a Complaint Form will be promptly sent to you if you request one by calling USBHPC's Customer Service Department.

Expedited Appeal Review

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

The expedited Appeal process is initiated upon receipt of a letter, fax and/or verbal request in person or by telephone from the Member, a practitioner on behalf of the Member or a representative of the Member. To request an expedited Appeal via telephone, please call Member Services at the number listed below.

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

If WHA determines that a delay of the requested review meets the criteria above, the Appeal is then reviewed under expedited conditions.

After an appropriate clinical peer reviewer has reviewed all of the information, a decision is rendered. The decision is then communicated verbally via telephone to the Member and practitioner no later than seventy-two (72) hours after the review began. A letter documenting the decision, whether it is to overturn or to uphold the original denial, is sent to the practitioner, with a copy to the Member, within two (2) working days of the decision. The letter contains all clinical rationale used in making the decision.

Independent Medical Review (IMR)

Members may seek an Independent Medical Review (IMR) through the Department of Managed Health Care (DMHC) whenever covered health care services

have been denied, modified or delayed by WHA, its contracting Medical Groups or its Participating Providers if the decision was based in whole or in part on findings that the proposed services were not Medically Necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a Coverage Decision. All Disputed Health Care Services are eligible for an IMR if the following requirements are met:

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

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

   c. In the absence of a. and b. above, the Member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the Member seeks an IMR.
2. The Disputed Health Care Service has been denied, modified or delayed based on WHA's decision that it is not Medically Necessary.
3. The Member has filed a Grievance with WHA and the decision has been upheld or remains unresolved past thirty (30) days. The DMHC (also called the "Department") may waive the requirement that the Member participate in the Plan's Grievance process in extraordinary or compelling cases.

There is no application or processing fee required.

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

To apply for an IMR, please call our Member Services Department between 8 a.m. and 6 p.m., Monday through Friday, at the number listed below to request the application form. Or if you prefer, you can come directly to our office or request the form in writing at:

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

Independent Medical Review of Experimental/Investigational Treatments

WHA excludes from coverage services, medication or procedures which are considered experimental and/or investigational and which are not accepted as standard medical practice or are not likely to be more beneficial for the treatment of a condition or illness than the available standard treatment.

If a specific procedure is requested and, after careful review by the appropriate medical personnel, the Plan's determination is that the therapy is experimental or investigational and, therefore, not a Covered Service, the Member will be notified of the denial in writing within five (5) business days of the decision.

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

The written request can be submitted to the Plan at:

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

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

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

Note: WHA is not financially responsible for payment to non-contracted providers that are not Prior Authorized.

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

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

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

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

Notice of Non-Discrimination

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable.

Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with:

Member Services Manager
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833, 888.563.2250
916.563.2250 or 711 (TTY)
fax 916.568.0126
memberservices@westernhealth.com
https://www.westernhealth.com/legal/grievance-form/

If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please follow the process outlined in the "Member Satisfaction Procedure" of the EOC or visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaints portal available at:

Website:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019 or 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Binding Arbitration

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

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

in a court of law before a jury, and instead are accepting the use of binding arbitration.

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

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

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

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

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

The arbitration procedure is governed by the JAMS rules applicable to commercial arbitrations. Copies of these rules and other forms and information about arbitration are available through the JAMS at jamsadr.com or 916.921.5300.

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

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

DEFINITIONS

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

Annual means once every 12 months.

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.

Behavioral Health Provider is a provider that provides diagnosis and treatment for both mental health disorders as well as substance use disorders.

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

Charges mean 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 or request for reconsideration or appeal made by a member or the Member's representative or Provider about their experience with WHA, a Medical Group and/or any WHA Participating Providers.

Contracted Rate means the amount payable for a particular service rendered by WHA Participating Providers and/or Medical Groups.

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

Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

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

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

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

Deductible means the amount of money a Member or family must pay in a calendar year for certain services before WHA will cover those services at the applicable Copayment in that calendar year.

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

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

Durable Medical Equipment means Medically Necessary standard equipment that can withstand repeated use, that is primarily and customarily used

to serve a medical purpose and that generally is not useful to a person in the absence of an illness or injury.

Educational Services means services or supplies whose purpose is to provide any of the following: behavioral training in connection with the activities of daily living, such as eating, working and self-care; instruction in scholastic skills such as reading, writing, and gaining academic knowledge for educational advancement; tutoring; educational testing; and preparation for an occupation.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy,
2. Serious impairment to bodily functions, or
3. 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.

Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-formulary drug.

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, or are not likely to be more beneficial for the treatment of a condition or illness than the available standard treatment.

Family Member means any of the following persons who meet the eligibility requirements and have duly enrolled in the Plan:

1. The legal spouse of the Subscriber; and
2. The qualifying Child of the Subscriber.

FDA-approved means drugs, medications and biologicals that have been approved by the Food and Drug Administration (FDA).

Four-tier Copay Plan means Tier 1 medications listed on the PDL are covered at the lowest tier copayment level, Tier 2 medications listed on the PDL are provided at the second tier copayment level, drugs not listed on the PDL (Tier 3) are covered at the third tier copayment level, and Tier 4 medications are covered at the fourth tier copayment level. There are a small number of drugs, regardless of tier, that may require prior authorization to ensure appropriate use based on criteria set by the WHA P&T Committee.

Generic medication is a Prescription drug that is medically equivalent to a Brand Name medication as determined by the FDA and meets the same standards as a Brand Name medication in all facets: purity, safety, strength and effectiveness.

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

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

Hospice Care means services provided by Participating Providers to Members who are certified in writing by a Participating Physician to be terminally ill (i.e., the Member's medical prognosis is that the life expectancy is twelve months or less), emphasizing supportive services and dietary counseling under the direction of a Participating Physician in accordance

with a written plan of care, including but not limited to services that are home-based.

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

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

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

Life-Threatening means either or both of the following:

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

Maintenance medication is any covered Prescription medication that is to be taken beyond sixty (60) days. Examples include medications for high blood pressure, diabetes, arthritis, allergy and oral contraceptives.

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

Medical Group or **Contracted Medical Group** means a group of Physicians who have entered into a written agreement with WHA to provide or arrange for the provision of Medical Services and to whom a Member is assigned for purposes of primary medical management. Medical Group includes contracted Independent Practice Associations, also called "IPAs."

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

Medically Necessary means that which WHA determines:

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

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

For MHSUD, "Medically Necessary" means a service or product addressing the specific needs of the particular Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following as determined by USBHPC:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of WHA or USBHPC or Members, or for the convenience of the patient, treating physician, or other health care provider.

"Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry,

psychology, clinical sociology, addiction medicine and counseling, and MHSUD treatment.

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.

Mental Disorders/Conditions means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Open Enrollment Period means the annual period defined by federal and state law during which eligible persons who have not previously enrolled in WHA may do so.

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

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

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

Participating Pharmacy is a pharmacy under contract with WHA, authorized to dispense covered Prescription medications to members who are entitled under the pharmacy benefit to receive them. Refer to the WHA Provider Directory for a list of Participating Pharmacies.

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

Participating Provider means a Contracted Medical Group, Participating Physician, Participating Hospital or other licensed health professional or licensed health facility who or which, at the time care is provided to a Member, has a contract in effect with WHA to provide Covered Services to Members. Information about Participating Providers may be obtained by telephoning WHA at the number listed below.

With respect to BHT services, “Participating Provider” includes qualified autism service (QAS) providers, QAS professionals and QAS paraprofessionals as those terms are defined in §1374.73(c) (3)-(5) of the California Health & Safety Code.

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

Preferred Drug List (PDL) is a listing of medications developed by WHA’s Pharmacy and Therapeutics (P&T) Committee as drugs of choice in their respective classes of “Tier 1 medication” or “Tier 2 medication.” Please note that a drug’s presence on the WHA PDL does not guarantee that the member’s physician will prescribe the drug. Members may request a copy of the PDL by calling WHA Member Services or view the document on WHA’s website at westernhealth.com.

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

alternatives and cost in determining their inclusion on the PDL.

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

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

Prescription medication is a drug which has been approved by the FDA and which can, under federal or state law, be dispensed only pursuant to a Prescription order from a duly licensed physician.

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

1. Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology;
2. Acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals to Specialist Physicians for Members who select such a Primary Care Physician; and
3. Is designated as a Primary Care Physician by the Medical Group.

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

Prior Authorization means written approval from the Medical Director, or from USBHPC for inpatient and certain non-routine outpatient MHSUD Services, before a service or supply is received. In most instances, this function is delegated to a Medical Group.

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

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

Psychiatric Emergency Medical Condition

1. Means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
    a. An immediate danger to himself or herself or to others.
    b. Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.
2. This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

Residential Treatment Center means a residential facility that provides services in connection with the diagnosis and treatment of MHSUD Disorders.

Sensitive Services means health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, obtained by a Member at or

above the minimum age specified for consenting to the service.

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

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

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

Subscriber means the person whose employment or other status (except for family dependency) is the basis for eligibility, who meets all applicable eligibility requirements and has enrolled in accordance WHA's enrollment procedures.

Tier 1

1. Most generic drugs and low cost preferred brands.

Tier 2

1. Non-preferred generic drugs;
2. Preferred brand name drugs; and
3. Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.

Tier 3

1. Non-preferred brand name drugs or;
2. Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
3. Generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4

1. Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;
2. Drugs that require the enrollee to have special training or clinical monitoring;
3. Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

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

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

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

WHA means Western Health Advantage.

APPENDIX A*
Preventive Services Covered Without Cost-Sharing

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

Service	Men	Women	Pregnant Women	Children
Abdominal Aortic Aneurysm, Screening[1]	x			
Abnormal Blood Glucose and Type 2 Diabetes Mellitus, Screening[2]	x	x		
Alcohol Misuse, Screening and Behavioral Counseling	x	x		
Alpha-Fetoprotein Testing[3]			x	
Annual Well Visits for Children[4]				x
Annual Well Visits for Men[5]	x			
Annual Women's Well Visits[6]		x		
Aspirin – low dose for the Prevention of Cardiovascular Disease and Colorectal Cancer: Preventive Medication[7]	x	x		
Asymptomatic Bacteriuria, Screening[8]			x	
Autism Screening by PCP[9]				x
Behavioral Counseling in Adults with Cardiovascular Risk Factors	x	x		
Birth Control[10]		x		
Blood pressure screening in children[11]				x
BRCA-Related Cancer in Women, Screening – Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing[12]		x		
Breast Cancer, Preventive Medications		x		
Breast Cancer, Screening[13]		x		
Breastfeeding Support, Supplies and Counseling[14]		x	x	
Cervical Cancer, Screening[15]		x		
Chlamydial Infection, Screening[16]		x	x	
Colorectal Cancer, Screening including Bowel Prep[17]	x	x		
Congenital Hypothyroidism, Screening[18]				x
Dental Caries in Preschool Children, Prevention[19]				x
Depression in Adults, Screening[20]	x	x		
Diet, Behavioral Counseling by PCP to Promote a Healthy Diet[21]	x	x		

Service	Men	Women	Pregnant Women	Children
Domestic Abuse, Screening and Counseling	x	x		x
Drug Use Screening in Adults 18+, Unhealthy	x	x		
Falls in Older Adults, Counseling, Preventive Medication and Other Interventions[22]	x	x		
Folic Acid Supplementation to Prevent Neural Tube Defects, Preventive Medication (Generic Required, Brand Name is Not Covered)[23]		x	x	
Gestational Diabetes Mellitus, Screening[24]			x	
Gonorrhea, Ocular Prophylactic Medication[25]				x
Gonorrhea, Screening[26]		x	x	
Group B Streptococcus, Screening			x	
Hearing Loss in Newborns, Screening[27]				x
Hepatitis B Virus Infection in Pregnant Women, Screening[28]			x	
Hepatitis B Virus Infection, Screening – Adolescent, Adult[29]	x	x		x
Hepatitis C Virus Infection, Screening[30]	x	x		x
High Blood Pressure in Adults 18+, Screening	x	x		
HIV, Screening[31]	x	x	x	x
HPV, Screening[32]		x		
Immunizations[33]	x	x		x
Intimate partner violence screening: women of reproductive age[34]		x		
Iron Deficiency – Anemia, Prevention – Counseling by PC[35]			x	x
Latent TB Infection, Screening[36]	x	x		x
Lead, Screening for at-risk children				x
Lipid Disorders in Adults, Screening[37]	x	x		
Lung Cancer, Screening[38]	x	x		
Major Depressive Disorder in Children and Adolescents, Screening[39]				x
Obesity in Adults, Screening[40]	x	x		
Obesity in Children and Adolescents, Screening[41]				x
Osteoporosis, Screening[42]		x		
Phenylketonuria (PKU), Screening[43]				x
Perinatal Depression: Preventive Interventions		x	x	
Postpartum Care			x	

Service	Men	Women	Pregnant Women	Children
Preeclampsia, Prevention: Low-dose Aspirin[44]			x	
Preeclampsia, Screening			x	
Prenatal Screening Under the California Prenatal Screening Program[45]			x	
Prevention of HIV Infection: Preexposure Prophylaxis[46]	x	x	x	x
Rh (D) Incompatibility, Screening[47]			x	
Sexually Transmitted Infections, Counseling[48]	x	x		x
Sickle Cell Disease in Newborns, Screening[49]				x
Skin Cancer, Counseling[50]	x	x		x
Statins for the Primary Prevention of Cardiovascular Disease[51]	x	x		
Sterilization Procedures[52]	x	x		
Syphilis Infection, Screening[53]	x	x	x	
Tobacco Use in Adults, Counseling and Interventions (Brand Name Medications Not Covered)[54]	x	x	x	
Tobacco Use in Children and Adolescents, Primary Care Interventions[55]				x
Visual Impairment in Children Ages 1 to 5 Years, Screening[56]				x

Footnotes:

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

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

2 Asymptomatic adults with sustained blood pressure greater than 135/80 mg Hg. (Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese.)

3 Once per pregnancy for pregnant individuals between 15 and 20 weeks' gestation.

4 Children under age 18.

[5] No-cost coverage provided by WHA but not mandated by state or federal law.

[6] Women of all ages. Services for well-woman preventive visits may be completed at a single visit, or as part of a series of preventive health visits that take place over time to obtain necessary services.

[7] Low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

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

[9] Infants at 9 months, 18 months, 24 months or 30 months.

[10] Birth control pills are no-cost for Generic only. Includes prescribed morning-after pill for women under age 17. WHA covers FDA-approved contraception for women with no copayment or cost sharing. See the section entitled “Family Planning” for the FDA-approved birth control methods. Birth control is not covered if excluded by your plan consistent with Federal and state law.

[11] Blood Pressure screening should occur in infants and children with specific risk conditions at visits before age 3 years.

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

[13] Mammography every 1 to 2 years for women 40 and older. Three-dimensional (“3D”) mammograms are not considered preventive.

[14] Lactation support, supplies and counseling during pregnancy and post-partum to promote and support breastfeeding.

[15] Women aged 21 to 65 who have been sexually active and have a cervix.

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

[17] Adults aged 45 to 75 years as recommended by your physician. Colonoscopies are also covered for a positive result on a non-colonoscopy test or procedure.

[18] Newborns.

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

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

[21] Adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared).

[22] Preventive care visits to discuss exercise interventions to prevent falls is a covered service for patients who are meet all of the following criteria: community-dwelling adults (excluding institutionalized, facility-based adults, such as those in Skilled Nursing Facilities), age 65 years or older, and at increased risk for fall.

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

[24] Pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

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

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

[27] All newborns by one (1) month of age; enrolled in early treatment if identified as hard of hearing by age six (6) months.

[28] Pregnant women at first prenatal visit.

[29] Adolescents and adults at increased risk.

[30] Recommended screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.

[31] All adolescents and adults aged 15 to 65 years, and all pregnant women.

[32] Every three years for women 30 and older.

[33] Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).

[34] Screening for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.

[35] Perform risk assessment or screening, as appropriate, per recommendations in current edition of American Academy of Pediatrics ("AAP") Pediatric Nutrition: Policy of the AAP (Iron chapter). In pregnant women, it is critical to distinguish iron deficiency anemia from physiologic anemia, as well as to identify other less common causes of anemia that may require treatment.

[36] Those at increased risk.

[37] For patients at higher cardiovascular risk (hypertension, diabetes mellitus, cigarette smoking, family history of premature CHD), it is suggested that follow-up lipid screening be performed in males between the ages of 25 to 30 and in females between the ages of 30 to 35. For patients at lower cardiovascular risk (none of the above factors), it is suggested that follow-up lipid screening be performed in males at age 35 and in females at age 45.

[38] Annual screening with low-dose computed tomography in adults ages 50 to 80 years who have a 20-pack/year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

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

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

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

[42] Women 65 and older and women younger than 65 at increased risk for osteoporotic fractures.

[43] Newborns.

[44] Use of low-dose aspirin after 12 weeks of gestation in women who are at high risk for preeclampsia.

[45] Once each month at weeks 4 through 28; twice a month at weeks 28 through 36; weekly at weeks 36 to birth.

[46] Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk for HIV acquisition.

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

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

[49] Newborns.

[50] Counseling for young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

[51] Low to moderate-dose statins for adults aged 40 to 75 years with no history of CVD, one or more CVD risk factors, and a calculated 10-year CVD event risk 10% or greater.

[52] Includes male sterilization procedure (vasectomy). Includes female sterilization procedures performed in connection with another procedure, such as cesarean delivery or abortion. Sterilization procedures for contraceptive purposes are not covered if excluded by your plan consistent with Federal law.

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

[54] Discussion/counseling about tobacco cessation interventions for those who use tobacco, and education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered. Brand name medication Chantix will be covered at no cost if specifically prescribed with a "do not substitute" or "prescribe as written" indication by a physician. Over-the-counter patches, gum, and lozenges are covered for two cessation attempts per year when prescribed by a physician.

[55] Discussion/counseling about tobacco cessation interventions for those who use tobacco, and education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered. Brand name medication Chantix will be covered at no cost if specifically prescribed with a "do not substitute" or "prescribe as written" indication by a physician. Over-the-counter patches, gum, and lozenges are covered for two cessation attempts per year when prescribed by a physician.

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

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PUBLISHED JANUARY 2024
WHA 297 12.23