Combined Evidence of Coverage and Disclosure Form (EOC/DF)

Effective January 1, 2022

Western Health Advantage

Health Maintenance Organization (HMO)
Basic Plan

Western Health Advantage

Contracted by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

There is no vested right to receive any particular benefit set forth in the Plan. Plan benefits may be modified. Any modified benefit (such as the elimination of a particular benefit or an increase in the member's copayment) applies to services or supplies furnished on or after the effective date of the modification.

WHA SERVICE AREA MAP

If you have questions about the covered service area and provider availability, you can reach WHA by calling 888.WHA.PERS (888.942.7377) toll-free or by emailing whapers@westernhealth.com.



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

Colusa: 95912 only (partial coverage)

El Dorado: 95613, 95614, 95619, 95623, 95633, 95634, 95635, 95636, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726, 95762 only (partial coverage)

Humboldt: All Zip Codes

Marin: All Zip Codes

Napa: All Zip Codes

Placer: 95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95722, 95736, 95746, 95747, 95765 only (partial coverage)

Sacramento: All Zip Codes

Solano: All Zip Codes

Sonoma: All Zip Codes

Yolo: All Zip Codes

Western Health Advantage Contracted Hospitals and Medical Centers

1. Providence St. Joseph Hospital Eureka
2. Providence Redwood Memorial Hospital
3. Healdsburg District Hospital
4. Providence Santa Rosa Memorial Hospital
5. Petaluma Valley Hospital
6. MarinHealth Medical Center
7. Sonoma Valley Hospital
8. Providence Queen of the Valley Medical Center
9. NorthBay Medical Center
10. NorthBay VacaValley Hospital
11. Woodland Memorial Hospital
12. Mercy General Hospital
13. Methodist Hospital of Sacramento
14. Mercy San Juan Hospital
15. Mercy Hospital of Folsom

IMPORTANT INFORMATION

To be completed by member

MEMBER NAME

ADDRESS

TELEPHONE NUMBER

ELIGIBILITY DATE

NAME OF PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN'S ADDRESS

PHARMACY LOCATION

PHARMACY TELEPHONE NUMBER

24-HOUR EMERGENCY CARE TELEPHONE NUMBER

CHANGES FOR 2022

Please make note of the following changes and/or clarifications to this Combined Evidence of Coverage and Disclosure Form for 2022. This list assists members to identify key changes. It is not intended to be a comprehensive list of changes.

Changes

p 1	Amendment to "WHA Service Area Map" to add Humboldt County
pp 18-20	Clarification to section "Introduction"
p 20	Clarification to section "Participating Providers"
p 20	Clarification to section "Non-Participating Providers"
p 22	Clarification to section "Referrals to Participating Specialists"
p 23	Amendment to section "Prior Authorization" for surgeries, tests and fertility preservation
pp 27-29	Clarification to section "Transition of Care and Continuity of Care"
p 29	Clarification to section "Access to Emergency Services"
pp 33-34	Amendment to section "Appeal and Grievance Procedure" to comply with State Law
p 40	Amendment to section "Binding Arbitration" from AAA to JAMS
p 44	Amendment to section "Outpatient Services" to clarify Fertility Preservation services
p 47	Clarification to section "Family Planning"
P 47	Addition of section "Fertility Preservation for Iatrogenic Infertility"
p 51	Clarification to section "Skilled Nursing Facility"
pp 51-52	Clarification to section "Behavioral Health Services" to comply with State Law
pp 53-56	Clarification to section "Principal Exclusions and Limitations"
p 63	Clarification to section "Termination for Nonpayment"
pp 68-72	Amendment to section "Definitions"
pp 73-78	Amendment to Appendix A to comply with USPSTF recommendations

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HEALTH PLAN BENEFITS AND COVERAGE MATRIX

Western Health Advantage (HMO)

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

MEMBER RESPONSIBILITY	COVERED BENEFITS
	Annual Deductible
$0	There are no deductibles for the medical benefits under this plan
	Annual Out-of-Pocket Maximum
	The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. Once copayment costs reach the annual out-of-pocket maximum, WHA will cover 100% of the covered services for the remainder of the calendar year. Amounts for non-covered services, and for certain covered services as noted below, do not count toward a member's out-of-pocket maximum.
$1,500	Self-only coverage
$1,500	Individual with Family coverage
$3,000	Family coverage
	Lifetime Maximum
Unlimited	There are no lifetime maximums for this plan

COST TO MEMBER	COVERED BENEFITS
	Preventive Care Services
$0	Preventive care services, including related laboratory tests and radiology, as outlined under the Preventive Services Covered without Cost-Sharing section of the Evidence of Coverage and Disclosure Form (EOC/DF). See additional benefit information at mywha.org/preventive: • Annual physical examinations and well baby care • Immunizations, adult and pediatric • Women's preventive services • Routine prenatal care and lab tests, first post-natal visit and breastfeeding support, supplies and counseling • Breast, cervical, prostate, colorectal and other generally accepted cancer screenings Note: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered "preventive," the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visits must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in the attached Health Plan Benefits and Coverage Matrix.

COST TO MEMBER	COVERED BENEFITS
	Member Tools and Resources
$0	MyWHA Wellness: online health and wellness tools, including a health assessment and progress trackers; and resources, including health education videos, podcasts, articles, and recipes
$0	Nurse24™ advice line: 24/7 telephonic and chat access to registered nurses, provided through Optum
$0	Global emergency services: urgent and emergency care support, including medical consultation and referrals, prescription assistance, hospital admission guarantee and emergency medical evacuation
	Professional Services
$15/visit	Office or virtual visits, Primary Care Physician (PCP)
$15/visit	Office or virtual visits, specialist
$0	Vision, hearing and audiological exams
$0	Family planning services, including injectable contraceptives
	Outpatient Services
	Outpatient Surgery
$15/visit	- Performed in office setting
$0	- Performed in facility
	Dialysis, infusion therapy and radiation therapy
$0	- Performed in office setting
$0	- Performed in facility
$0	Laboratory tests, X-ray and diagnostic imaging
$0	Allergy testing and allergy shots
	Hospitalization
$0	Facility fees—semi-private room and board and hospital services for acute care or intensive care, including: - Newborn delivery (private room when determined medically necessary by a participating provider) - Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy, blood transfusion services, rehabilitative services, and nursery care for newborns
$0	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services

COST TO MEMBER	COVERED BENEFITS
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:
$15/visit	- Physician's office
$15/visit	- Urgent care virtual visit
$15/visit	- Urgent care center
$50/visit	- Emergency room (waived if admitted)
$0	- Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Durable Medical Equipment (DME)
$0	Durable medical equipment, when determined by a participating physician to be medically necessary and when authorized in advance by WHA, including: - Diabetic supplies - Orthotics and prosthetics - Eyeglasses or contact lenses following cataract surgery
	Behavioral Health Services: **Mental Health Disorders and Substance Use Disorders**
$15/visit	- Office or virtual visits and group therapy
$0	- Other outpatient items and services, including intensive outpatient, partial hospitalization, day treatment programs and home-based applied behavioral analysis for treatment of autism
$0	- Inpatient hospital services, including detoxification—provided at a participating acute care facility or residential treatment center
$0	- Inpatient professional services, including physician services
	Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).
	Other Health Services
$15/visit	Physical, occupational and speech therapy NOTE: The copayment listed above is required for any physical, occupational or speech therapy rendered, regardless of the point of service or therapeutic intent.
$0	Skilled nursing facility, semi-private room and board, when medically necessary and arranged by a primary care physician, including drugs and prescribed ancillary services, up to 100 days per calendar year
$0	Home health care when prescribed by a participating physician and determined to be medically necessary
$0	Habilitation and outpatient rehabilitative services
$0	Inpatient rehabilitation
$0	Hospice services
50% of charges*	Infertility testing and treatment services—artificial insemination**

COST TO MEMBER	COVERED BENEFITS
	Other Health Services (continued)
$15/visit	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., no PCP referral required. NOTE: 20 visits per year maximum (acupuncture and chiropractic combined). • Acupuncture • Chiropractic care**
Amounts in excess of maximum benefit	Hearing aids or ear molds; $1,000 maximum benefit per 36 months**
	Prescription Coverage**
	Prescription drugs are not covered by WHA. They are covered through OptumRx, the supplemental coverage provided by your employer. More information about prescription drug coverage is available at www.optumrx.com/calpers.
$0	Generic Formulary and prescribed over-the-counter contraceptives for women
	Walk-in pharmacy (up to 30-day supply)
$5	Generic Formulary medication
$20	Brand Formulary medication
$50	Non-Formulary medication
	Mail order (up to 100-day supply), up to $1,000 annual maximum
$10	Generic Formulary medication
$40	Brand Formulary medication
$100	Non-Formulary medication

* Charges are based upon WHA's contracted rates.

** Copayments do not contribute to the medical out-of-pocket maximum.

WHA RATES:
FOR CONTRACTING AGENCY EMPLOYEES AND ANNUITANTS

2022: Region 1

Single	2-Party	Family
741.26	1,482.52	1,927.28

WHA RATES:
FOR STATE EMPLOYEES AND ANNUITANTS

2022

Single	2-Party	Family
741.26	1,482.52	1,927.28

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 888.942.7377 or TTY 888.877.5378.

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 888.942.7377, o al TTY 888.877.5378 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 888.942.7377 或聽障人士專線(TTY) 888.877.5378。

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 888.942.7377, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG
Kung ikaw, o ang iyong tinutulangan, 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 888.942.7377 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.942.7377 이나 청각 장애인용 TTY 888.877.5378 로 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 888.942.7377 համարով կամ TTY 888.877.5378՝ 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 آدونتیج) داشته با ید حق اید زرا دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.942.7377 تماس بگیرید. افراد ناشنوا می توانند به شماره888.877.5378 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 888.942.7377 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

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、888.942.7377 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、888.877.5378 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 بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.942.7377، أو برقم الهاتف النصي (TTY) لضعاف السمع والبكم 888.877.5378.

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, 888.942.7377 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ក្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.942.7377 ឬ TTY សម្រាប់អ្នកក្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

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 888.942.7377 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

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, 888.942.7377 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.942.7377 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378

PRIVACY NOTICE

Western Health Advantage ("WHA") is required by law to maintain the privacy of your health information and provide you notice about our legal duties and privacy practices. We must follow the practices described in notice while it is in effect.

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

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

Protecting Your Privacy

At Western Health Advantage (WHA), we understand the importance of keeping your health information confidential and we are committed to using your health information consistent with State and Federal law. WHA protects your electronic, written and oral health information throughout our organization.

Protected Health Information

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

- your name, address and other demographic information
- personal information about your circumstances (example: medical information for purposes of diagnosis or treatment with or from physicians, nurses and facilities)

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you, except psychotherapy notes and information to be used in a lawsuit or administrative proceedings. You can ask us how to do this.
- We will provide a copy or, upon your request, a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. You can ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and will say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.

- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

- You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the notice electronically. Contact WHA Member Services. We will provide you with a paper copy promptly. You can also find this notice on our website at: westernhealth.com.

Choose someone to act for you

- If you have given someone power of attorney or if someone is your legal guardian or personal representative, that person can exercise your rights and make choices about your health information.
- We will make sure the person has authority to act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this Notice.
- You can also file a complaint with the federal government, by writing or calling or online, using the information at the end of this Notice.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to authorize us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In all situations other than those described in the next section, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization for:

- Marketing purposes
- Sale of your information

In the case of sensitive information, like HIV test results or psychotherapy notes, your written authorization will be secured in most situations.

Our Uses and Disclosures

We must disclose your PHI:

- To you or your personal representative; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

You have the right to authorize or deny the release of PHI for purposes beyond treatment, payment,

and health care operations. We may use and disclose your health information without your authorization as permitted or required by Federal, State, or local law. In instances where your health information is not used for such purposes, we would secure your written authorization prior to sharing it.

How do we typically use or share your health information?

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.
- We can send you communications regarding our fundraising activities. You have the right to choose not to receive such communications.

Example: We use health information about you to develop better services, including member satisfaction surveys, compliance and regulatory activities, and grievance and appeals activities.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with a hospital or other health care provider to coordinate payment for health services provided to you. We may also provide information to the subscriber of a family policy or another individual for the purpose of handling or understanding medical bills, managing claims, reconciling your deductibles or out of pocket maximum payments.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company/employer contracts with us to provide a health plan, and we provide your company/employer with certain information (excluding medical information) to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information, without your written authorization, in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Disaster relief

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director or forensic pathologist when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law such as licensing and quality of care
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

For more information see:

https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you authorize us in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

As part of normal business, WHA shares your information with contracted providers (e.g. medical groups, hospitals, pharmacy benefit management companies, social service providers, etc.) or business associates that perform functions on our behalf or with whom we have organized health care arrangements. In all cases where your PHI is shared with providers, plan sponsors and business associates, including those who may have databases stored or accessed outside of the United States, we have a written contract that contains language designed to protect the privacy and security of your health information. All of these entities are required to keep your health information confidential and protect the privacy and security of your information in accordance with State and Federal laws.

For more information see:

https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

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*****IMPORTANT*****

WHA does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or medical group.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available on our web site at westernhealth.com, or upon request, we will mail a copy to you.

This Notice is effective January 1, 2020 and remains in effect until changed.

If you want to file a Complaint

You can write to us at:

Western Health Advantage
Attention: Privacy Complaints
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

You can also call us at: 888.WHA.PERS (888.942.7377) toll-free or 888.877.5378 TTY

Or email us at: privacy@westernhealth.com

For Complaints to the Federal Government

Go to the web address below or call or write to:

U.S. Department of Health
and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

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/calpers 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 the group health plan. The Group Service Agreement between WHA and CalPERS must be consulted to determine governing contractual provisions as to the exact terms and conditions of coverage. You may request to see the Group Service Agreement from CalPERS. 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 Group Service Agreement and this EOC/DF.

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

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

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under your EOC/DF and that you or your Family Member might need: family planning; contraceptive services,

including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; 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 CalPERS 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. You will be provided with a copy of WHA's Provider Directory, which at the time it was printed and sent was current. However, this list is updated so changes may have occurred that could affect your Physician choices. WHA provides printed Provider Directories on demand. If you need another copy of the directory, contact WHA CalPERS 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/calpers.

Liability of Member for Payment

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.

Emergency Services

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

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

Non-Participating Providers

Any coverage for services provided by a Physician or other health care provider who is not a Participating Provider requires written Prior Authorization before the service is obtained, except in 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. 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 and pediatric subspecialists and obstetrician/gynecologists are designated PCPs. Some may practice only as Specialist Physicians. Visit westernhealth.com/calpers 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 WHA CalPERs Member Services or go to westernhealth.com/calpers 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.

Changing Your Primary Care Physician

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

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

Transferring to another Primary Care Provider or Medical Group

Any individual Member may change PCPs or Medical Groups/IPAs as described in this EOC/DF. If the relationship between you and a Plan physician is unsatisfactory, then you may submit the matter to the Plan and request a change of Plan physician. 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 and annual eye exams are included in the Advantage Referral program and do not require a PCP referral or Prior Authorization, as long as the provider is listed in the WHA Provider Directory and participates in the Advantage Referral program.

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

Advantage Referral

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

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.

- Behavioral/Mental Health Services: See the back of your WHA ID card for the telephone number for your mental health 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.
- Acupuncture and chiropractic services.

WHA also offers all members access to California-licensed, registered nurses through Nurse24. Screening, triage, and health education services are available 24 hours a day, 7 days a week. Use Nurse24 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 behavioral health 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, behavioral health provider, acupuncturist or chiropractor 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;
- All infertility services (if infertility services are covered under your plan);
- 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); and
- Inpatient and non-routine outpatient behavioral health services, including outpatient electroconvulsive therapy, intensive outpatient program, partial hospitalization program, Psychological testing, repetitive transcranial

magnetic stimulation, applied behavioral analysis and office-based opioid treatment.

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 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 CalPERS 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 Services

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 attached Health Plan Benefits and Coverage Matrix 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.

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 at 877. 793.3655. Explain your condition to your doctor, the Physician on call at your doctor's office, or the nurse on the Nurse Advice Line and he/she will advise you. In the event you are not able to reach your Physician or the Nurse Advice Line, you may go to an Urgent Care facility affiliated with your Medical Group. For more information about the Nurse Advice Line, please see "Principal Benefits and Covered Services," "Other Health Services."

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

Post-Stabilization Care

Once your Emergency Medical Condition is stabilized, your treating health care provider at the hospital emergency room may believe that you require additional post-stabilization services prior to your being safely discharged. If the hospital is a non-Participating Hospital, the hospital will contact your assigned Contracted Medical Group or WHA to obtain timely Prior Authorization for these post-stabilization services. If WHA or its Contracted Medical Group determines that you may be safely transferred to a Participating Hospital and you refuse to consent to the transfer, you will be financially responsible for 100% of the cost of services provided to you at the non-Participating Hospital after your Emergency Medical Condition is stable. Also, if the non-Participating Hospital is unable to determine your name and WHA contact information in order to request Prior Authorization for post-stabilization services, it may lawfully bill you for such services. If you feel that you were improperly billed for services that you received from a non-Participating Hospital, please contact WHA CalPERS 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 behavioral health specialist**
  - Routine: 15 business days

    - Urgent: 48 hours if no prior authorization required
    - Urgent: 96 hours prior authorization required
- **Visit with non-physician behavioral health provider**
    - Routine: 10 business days
- **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 Nurse24 nurse advice line 24 hours per day, 7 days per week, 365 days per year by calling 877.793.3655 toll-free or 800.877.8793 TTY.

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 800.877.8793.

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. Call 877.793.3655 or visit mywha.org/healthsupport to chat with a nurse or to send a secure email.

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 WHA CalPERS Member Services or go to westernhealth.com/calpers 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.

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

WHA and/or the Medical Group will require a non-Participating Provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers of similar services who are 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. Facility-based services must be provided by a licensed hospital or other licensed health care facility. 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 CalPERS Member Services Department prior to enrollment, within (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/calpers, 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 WHA CalPERS Member Services Department at 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 WHA CalPERS Member Services Department at 888.WHA.PERS 7:00 am to 8:00 p.m. Pacific Time seven (7) days a week.

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

Access to Emergency Services

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

WHA CONTACT INFORMATION

Member Services

For questions about your benefits, inquiries about your doctor or filling a prescription you can reach us toll-free at 888.WHA.PERS or via e-mail at whapers@westernhealth.com. Our dedicated Member Services team is available to support you from 7:00 am to 8:00 p.m. Pacific Time seven (7) days a week and 8:00 a.m. to 5:00 p.m. Pacific Time Monday through Saturday, for Utilization Management (including prior authorizations), except WHA holidays.

If you have questions about the covered service area and provider availability, you can reach us toll-free at 888.WHA.PERS or email us at whapers@westernhealth.com.

WHA Nurse Advice (Nurse24)

If you need medical advice after regular business hours you can call WHA's Nurse Advice Line (Nurse24) at 877.793.3655. Nurse24 is staffed by registered nurses who are licensed in the State of California and have been trained in telephone triage and screening. Nurse24 is available to you 24 hours a day, seven days a week. Nurse24 is also available via "live chat" and "email messaging," which can be accessed at mywha.org/healthsupport.

Note: Interpreter services are available. For relay assistance services, please call 800.877.8793 (Voice/TTY/ASCII) or 800.855.4000 (Sprint TTY Operator Services).

FINANCIAL CONSIDERATIONS

Prepayment Fees

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

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 your employer in writing sixty (60) days prior to your contract renewal effective date, 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. See the "Liability of Member for Payment" section under the "Introduction" to this EOC/DF for more information. Also see the attached Health Plan Benefits and Coverage Matrix 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.

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. **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.** 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 WHA CalPERS 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 the attached Health Plan Benefits and Coverage Matrix, 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 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 for hospital or physician services provided in an emergency. If you were billed more than your applicable copayment 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.

Out-of-Pocket Maximum Liability

The annual out-of-pocket maximum liability (OOP) for Covered Services is described in the

attached Health Plan Benefits and Coverage Matrix. Please refer to the attached Health Plan Benefits and Coverage Matrix 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 you pay during the calendar year (including medical, pharmacy, acupuncture, and behavioral health) will be applied to the OOP, except as described below. When you pay a Copayment for Covered Services, ask for and keep the receipt. When the receipts add up to the amount of the annual OOP, submit your receipts to WHA. Please call our Member Services Department to find out where to submit your receipts. After 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 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 the attached Health Plan Benefits and Coverage Matrix, 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:

- Artificial Insemination
- Hearing Aids
- Outpatient Prescription Drugs
- Vision Services
- Any payments for any benefits purchased separately as a rider.

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

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/calpers.

What Are My Rights?

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

- To be provided information about WHA's organization and its services, providers and practitioners, managed care requirements, processes used to measure quality and improve Member satisfaction, and your rights and responsibilities as a Member.
- To be treated with respect and recognition of your dignity and right to privacy.
- To actively participate with practitioners in making decisions about your health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending Physician.
- To expect candid discussion of appropriate, or Medically Necessary, treatment options regardless of cost or benefit coverage.
- To voice a Complaint or to appeal a decision to WHA about the organization or the care it provides, and to expect that a process is in place to assure timely resolution of the issue.
- To make recommendations regarding WHA's Member Rights and Responsibilities policies.

- To know the name of the Physician who has primary responsibility for coordinating your care and the names and professional relationships of others who may provide services, including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures.
- To receive information about your illness, the course of treatment and prospects for recovery in terms that can be easily understood.
- To receive information about proposed treatments or procedures to the extent necessary for you to make an informed consent to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment, medically significant risks associated with it, alternate courses of treatment or non-treatment including the risks involved with each and the name of the person who will carry out a planned procedure.
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with your care, except as permitted by law or as necessary in the administration of the Health Plan. WHA's policies related to privacy and confidentiality are available to you upon request.
- To full consideration of privacy and confidentiality around your plan for medical care, case discussion, consultation, examination and treatment, including the right to be advised of the reason an individual is present while care is being delivered.
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment, as well as the name of the practitioner scheduled to provide your care.
- To be advised if the Physician proposes to engage in or perform human experimentation within the course of care or treatment and to refuse to participate in such research projects if desired.
- To be informed of continuing health care requirements following discharge from a hospital or practitioner's office.
- To examine and receive an explanation of bills for services regardless of the source of payment.
- To have these Member rights apply to a person with legal responsibility for making medical care decisions on your behalf. This person may be your Physician.
- To have access to your personal medical records.
- To formulate advance directives for health care.

What Are My Responsibilities?

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

- To know, understand and abide by the terms, conditions, and provisions set forth by WHA as your Health Plan. The EOC/DF document you received at the time of enrollment and/or that is available on WHA's website at westernhealth.com/calpers (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.

MEMBER SATISFACTION PROCEDURE

WHA strives to provide exceptional health care services to you if you have a concern about your medical care, you should discuss it with your PCP. If you have a concern, or need help answering your questions, clarifying procedures or investigating Complaints, call Member Services toll-free at 888.WHA.PERS 7:00 am to 8:00 p.m. Pacific Time seven (7) days a week.

If you prefer, you can visit or write to:

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

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

Information and Assistance in Other Languages

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

Pharmacy Grievance Procedures

All pharmacy benefits are managed by OptumRx. Please refer to your OptumRx Outpatient Prescription Drug Plan Evidence of Coverage booklet for Pharmacy Grievance procedures or you may contact OptumRx's Customer Care at 855.505.8110.

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.WHA.PERS for assistance. If your Complaint is not resolved to your satisfaction after working with a Member Services representative, you 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.

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.

Department of Managed Health Care Information

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your health plan at the number listed below and use your health plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan or a Grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, Coverage Decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. **The department also has a toll-free telephone number, 888.466.2219, and a TDD line, 877.688.9891, for the hard of hearing and speech impaired. The department's Internet Web site, 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 Mental Health and Alcoholism and Substance Use Disorder Benefits

HAI-CA administers all levels of review under WHA's Grievance Process for Complaints regarding mental health or substance use disorder/detoxification services. If you have an inquiry or concern regarding your mental health or chemical dependency/detoxification benefits, you should first call HAI-CA's Customer Service Department at 800.424.1778.

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 HAI-CA's Grievance Unit at:

Attn: Comment Coordinator
PO Box 710430
San Diego, CA 92171
800.424.1778

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

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 Investigational/Experimental Treatments

WHA excludes from coverage services, medication or procedures which are considered investigational and/or experimental and which are not accepted as standard medical practice 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.

Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the Grievance process described above, you have additional dispute resolution options, as follows below:

Eligibility Issues: Issues of eligibility must be referred directly to CalPERS at:

CalPERS Health Account
Management Division
Attn: Enrollment Administration
P.O. Box 942715
Sacramento, CA 94229-2715

CalPERS Customer Service and
Outreach Division toll-free telephone number:
888 CalPERS (or **888**-225-7377)
(916) 795-1277 fax

Coverage Issues: A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this EOC booklet. It does not include a plan or contracting provider decision regarding a Disputed Health Care Service.

If you are dissatisfied with the outcome of WHA's internal appeal process or if you have been in the process for 30 days or more, you may request review by the DMHC, proceed to court, or initiate binding arbitration. Upon exhaustion of the DMHC review process, you may then request CalPERS Administrative Review. You may not request CalPERS Administrative Review if you decide to proceed to court or initiate binding arbitration.

Malpractice: YOU MUST SUBMIT ISSUES OF MALPRACTICE TO BINDING ARBITRATION.

Bad Faith: YOU MUST SUBMIT ISSUES OF BAD FAITH TO BINDING ARBITRATION.

CalPERS Administrative Review

If you remain dissatisfied with the DMHC's determination or the IMR's determination, you may request an Administrative Review. You must exhaust WHA's internal Grievance process, the DMHC's process or the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC's determination or the IMR determination letter. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Review, not to exceed 30 days.

The request must be mailed to:

CalPERS Strategic Health Operations Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information WHA may have regarding your dispute with your request for Administrative Review, please note that WHA may require you to sign an authorization form to release this information.

In addition, if CalPERS determines that additional information is needed after WHA submits the information it has regarding your dispute, CalPERS may ask you to sign an Authorization to Release and Disclose Health Information (ARDHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send copies of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and

mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For urgent appeals, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if you request an IMR at the same time you submit a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue its determination until the IMR determination is issued.

Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing.

Only claims involving covered benefits are eligible for an Administrative Hearing.

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination.

Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but are not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members Under the Administrative Procedure Act

- Right to records, generally. You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from WHA and/or CalPERS, as applicable.
- Records subject to attorney-client privilege. Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- Attorney Representation. At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor WHA will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- Right to experts and consultants. At any stage of the proceedings, you may present

information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor WHA will reimburse you for the costs of experts, consultants or evaluations.

Binding Arbitration

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

As a condition of your membership in WHA, you agree that any and all disputes between yourself (including any heirs or assigns) and Western Health Advantage, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and 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 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. The location of the arbitration shall be Sacramento, California.

APPEAL CHART

Adverse Benefit Determination (ABD)

Appeals Process Member Receives ABD

Standard Process
180 days to file Appeal.

Internal Review
Final Adverse Benefit Determination (FABD) issued **within 30 days** from receipt of request.

Request for DMHC Review
Member must request DMHC Review **within six (6) months** of FABD.*

DMHC Review
FABD must be reviewed **within 30 days** from date DMHC Review requested.

CalPERS Administrative Review (AR)
Member must file within 30 days of DMHC determination for benefit decisions, or IMR decision for cases involving Medical Judgment. CalPERS will attempt to notify Member of determination **within 60 days**.

Urgent Process
180 days to file Appeal.

Internal Review
Final Adverse Benefit Determination (FABD) issued within reasonable timeframes given medical condition but in no event longer than **72 hours**.

Request for DMHC Review
Member should submit request for Urgent DMHC. Review as soon as possible, but in no event longer than **six (6) months** of FABD.*

DMHC Review
FABD must be reviewed within reasonable timeframes given medical condition but generally completed **within three (3) days** from receipt of request (**seven (7) days** for an experimental/investigational service).

CalPERS Administrative Review (AR)
Member should file as soon as possible, but in no event longer than **30 days** of IMR decision. CalPERS will notify Member of AR determination **within three (3) business days** of receipt of all pertinent information.

Process continued on following page

*For FABDs that involve "Medical Judgment," the Member must request IMR from DMHC prior to submitting a CalPERS Administrative Review.

Administrative Hearing Process

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Request for Administrative Hearing
Member may request Administrative Hearing
within 30 days of CalPERS AR determination.

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Administrative Hearing
CalPERS submits a statement of issues to Administrative Law Judge.
Member has right to attorney, to present witnesses and evidence.

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Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to
California Administrative Procedures Act.

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CalPERS Board of Administration
Adopts, rejects or returns proposed decision for additional evidence.
If adopts, decision becomes final decision.

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Member May Request
Reconsideration by Board or appeal final decision

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 (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 Participating Provider providing your annual eye exam;
- A Participating Behavioral Health Provider that has been authorized, as required by HAI-CA.

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

You will be responsible for applicable Copayments as described on the attached Health Plan Benefits and Coverage Matrix or in this EOC/DF. You are also responsible for any 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

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 (due to a decision to discharge earlier made by the treating physicians in consultation with the mother), a follow-up visit for you and your newborn, within 48 hours of discharge is covered when prescribed by a 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.

Please refer to the attached Health Plan Benefits and Coverage Matrix for copayment responsibility.

- 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.

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;
- Eye examinations (including eye refraction);
- Hearing examinations;
- 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, unless excluded.
- Rehabilitative services including physical therapy, speech therapy and occupational therapy, when authorized in advance and Medically Necessary;
- 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 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.
- Fertility preservation is covered for members who will be undergoing a medically necessary treatment that can result in infertility.

Limits on Rehabilitative and Habilitative services will not be combined

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.

Other Health Services

Acupuncture and chiropractic care are covered through Landmark Healthplan of California, Inc., a Knox-Keene licensed specialty plan. Acupuncture or Chiropractic benefit details will appear on the attached Health Plan Benefits and Coverage Matrix. For full disclosure of benefits provided through Landmark Healthplan, please see the Landmark Schedule of Benefits or Evidence of Coverage available at www.lhp-ca.com. To access the Schedule of Benefits, select "Members" and "Expanded Plan" under "Chiropractic/Acupuncture Benefit". For a printed copy, you may contact WHA CALPERS Member Services at 888.WHA.PERS. 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 and chiropractic benefits.

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 FDA-approved cervical cancer screening test;
- 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 would apply to covered services.

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 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/calpers.

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.
5. Health care services customarily provided by researchers free of charge to participants in the clinical trial.

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.

Diabetes 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 the 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 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 are items are covered and available under your OptumRx Outpatient Prescription Drug Plan:

- testing strips;
- lancets;
- insulin syringes.

Disease Management (DM) programs are a covered 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
- Congestive Heart Failure (CHF) program for Members 18 years and older
- Coronary Artery Disease (CAD) program for Members 18 years and older
- Chronic Obstructive Pulmonary Disease (COPD) for Members 18 years and older
- Diabetes program for Members 18 years and older
- High-Risk Maternity 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/calpers.

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 attached Health Plan Benefits and Coverage Matrix.

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

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, the Member should call "911." WHA covers ambulance services if you reasonably believe you are in an emergency situation.

Family Planning: WHA covers FDA-approved contraception. This includes patient education, counseling, and follow-up including, but not limited to, managing side effects, ensuring adherence, and services related to device insertion and removal.

FDA-approved contraception for women is 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),
- female sterilization procedures,
- sterilization implant.

OptumRx 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.

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 for 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.

Gender Reassignment Surgery is one treatment option for Gender Identity Disorder. Gender Reassignment Surgery and associated services are covered when Medically Necessary. Covered Benefits include clinically appropriate services for the complete treatment of GID including medical, psychiatric, hormonal, and surgical treatments according to the World Professional Association of Transgender Health (WPATH) Standards of Care (SOC) Version 7.

Hearing Aids are covered with a $1,000 benefit maximum, limited to one device per ear every thirty-six (36) months.

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. "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:

- 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).

Home Self-Injectable Medications are covered regardless of whether you have Prescription coverage. These are injectable drugs that you or your caregiver can safely administer with minimal training by health professionals.

Hospice Care is covered when you have met the Hospice Care requirements below and request Hospice Care instead of traditional 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 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.

Infertility Services

Infertility services, including diagnosis and treatment of the Member's infertility condition (including Artificial Insemination), are covered. Infertility is defined as (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual intercourse without contraception or (2) the presence of a demonstrated condition recognized by a physician as a cause of infertility. A woman without a male partner who is unable to conceive may be considered infertile if she is unable to conceive or produce conception after at least twelve (12) cycles of donor insemination; these 12 cycles are not covered by the Plan. The Member pays a Copayment equal to fifty percent (50%) of the Plan's contracted rate of payment to each Plan Provider of services for all covered infertility services.

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.

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.

Preventive Services and Immunizations:

Appendix A lists the Preventive Services and Immunizations covered by WHA. 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 member 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 all recommended immunizations at www.cdc.gov/mmwr/preview/mmwrhtml/rr5515a1.htm.

Preventive care and screenings recommended by the Health Resources Services Administration are also generally included as benefits and listed in Appendix A.

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 the attached Health Plan Benefits and Coverage Matrix. 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 the attached Health Plan Benefits and Coverage Matrix for more information.

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.

Nurse Advice Line (Nurse24). WHA contracts with Optum to provide around-the-clock nurse advice line services. Nurse24 is staffed by registered nurses who are licensed in the State of California and have been trained in telephone triage and screening. Nurse24 is available to you 24 hours a day, seven days a week by calling 877.793.3655. Nurse24 is also available via "live chat" and "email messaging," which can be accessed at mywha.org/healthsupport. Nurse24 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 behavioral health concerns;
- identifying and addressing emergency medical concerns, including help for behavioral health 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 800.877.8793 (Voice/TTY/ASCII) or 800.855.4000 (Sprint TTY Operator Services).

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

Outpatient Prescription Drugs. WHA does not provide outpatient prescription drug coverage as a Covered Benefit, except for limited classes of prescription drugs that are integral to treatments

covered as basic health care services. Outpatient prescription drug benefits are instead covered and administered by OptumRx. Members should review the OptumRx Outpatient Prescription Drug Plan Evidence of Coverage booklet for details regarding the Outpatient Prescription Drug Program.

Members may contact OptumRx's Customer Care at 855.505.8110 with questions or to request a copy of the booklet.

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.

Skilled Nursing Facility, care to a maximum of one hundred (100) days in each calendar year is covered if Medically Necessary. This one hundred (100) day maximum is a combined benefit maximum for all subacute stays.

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 if ordered by a Participating Physician and approved by WHA's Medical Director in advance, subject to the terms and conditions 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 expenses of a live donor to the extent these services are not covered by another plan or program.

Behavioral Health Services

WHA has contracted with Human Affairs International of California (HAI-CA), an affiliate of Magellan Behavioral Health, to manage your mental health and substance use disorder benefits. If you need behavioral health treatment or have questions about your behavioral health benefits, please call HAI-CA at 800.424.1778.

Mental Health Services

(A) 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 HAI-CA.

(B) 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.

> **Office visits:** include, but are not limited to, mental health individual and group evaluation and therapy, psychological testing, office based behavioral health treatment for autism, and repetitive transcranial magnetic stimulation.
>
> **Outpatient other services** include intensive outpatient program, partial hospitalization/day treatment and outpatient electroconvulsive therapy, home based behavioral health treatment for autism, and non-emergency psychiatric transportation.

The following office visits/outpatient services require Prior Authorization by HAI-CA:

- Outpatient electroconvulsive therapy;
- Intensive outpatient program;
- Partial hospitalization program;
- Repetitive transcranial magnetic stimulation;
- Psychological testing when necessary to evaluate a Mental Disorder; 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,
- 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 HAI-CA.

Note: Inpatient services, Office visits and Outpatient services are subject to the Copayment listed on the attached Health Plan Benefits and Coverage Matrix.

Alcoholism and Substance Use Disorder Services

(A) Inpatient

Inpatient services for evaluation and care for substance use dependency are covered. This benefit includes detoxification services. Services require Prior Authorization by HAI-CA and must be provided at a participating facility including Residential Treatment Center.

(B) Outpatient

Outpatient services for evaluation and care for substance use dependency are covered and include detoxification services, and must be provided by a Participating Provider.

Office visits include, but are not limited to, psychological testing, substance use disorder individual and group counseling, medical treatment for withdrawal symptoms, office-based opioid treatment, substance use disorder methadone maintenance treatment, and substance use disorder outpatient detoxification.

Outpatient other services include intensive outpatient program and partial hospitalization/day treatment.

The following office visits/outpatient services require Prior Authorization by HAI-CA:

- Intensive outpatient program;
- Partial hospitalization program/day treatment;
- Office-based opioid treatment; and
- Psychological testing.

Residential recovery services are covered with Prior Authorization by HAI-CA.

Methadone maintenance treatment is covered with Prior Authorization from HAI-CA.

Note: Inpatient services, Office visits and Outpatient services are subject to the Copayment listed on the attached Health Plan Benefits and Coverage Matrix.

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.

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 attached Health Plan Benefits and Coverage Matrix. WHA has no pre-existing condition exclusions for any 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.
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 without 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 Investigational/Experimental 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 for 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, glasses or contact lenses in connection with cataract removal.)
10. Repair of hearing aids after the covered one-year warranty period, hearing aids batteries and replacement parts.
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. non-dental surgical and hospitalization procedures required due to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate,
    b. when integral to reconstructive surgery for cleft palate or

c. surgery or splints on the maxilla or mandible to correct temporomandibular joint disease (TMJ) or other medical conditions.

d. 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. All immunizations required to obtain or maintain employment or for 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, or Residential services under Mental Health/Substance Use Disorder 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;
    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 Condition.
37. Stress management therapy, unless Medically Necessary for mental health and substance use disorders.
38. Mental health treatment of pain, unless Medically Necessary.
39. Group homes (except Medically Necessary residential treatment prior authorized by HAI-CA).
40. Wilderness programs, therapeutic boarding schools, and equestrian / hippotherapy, unless Medically Necessary for mental health and substance use disorders.
41. 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.
42. Hypnotherapy, unless Medically Necessary for mental health and substance use disorders.
43. BHT services rendered to provide respite, day care, or Educational Services, or reimbursement to a parent for participating in the treatment.
44. Treatment of short stature unless treatment is Medically Necessary.
45. 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 when 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.

46. Home birth delivery.
47. Services and supplies in connection with the reversal of voluntary sterilization.
48. Services related to assisted reproductive technology to treat infertility, unless covered under "Infertility Services". This includes, but is not limited to:
    a. harvesting or stimulation of the human ovum,
    b. ovum transplants,
    c. donor semen or eggs (and services related to their procurement and storage),
    d. services or medications to treat low sperm count,
    e. In Vitro Fertilization (IVF),
    f. Zygote Intrafallopian Transfer (ZIFT), and
    g. preimplantation genetic screening.
49. Acupressure (unless provided through the acupuncture benefit).
50. Sex surrogacy services.

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 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, HAI-CA or MESVision expense. WHA, HAI-CA, MESVision 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, HAI/CA or MESVision, 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 provide or attempt to arrange for Covered Services according to their best judgment within the limitations of available facilities or personnel. If the Plan is unable to provide services it will refer Members to the nearest hospital for Emergency Services and later

provide reimbursement to the Member for such Covered Services.

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

Information pertaining to eligibility, enrollment and termination of coverage can be obtained through the CalPERS website at www.calpers.ca.gov or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS. It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Health Account Management Division at:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715

Or call:
888 CalPERS (or **888**-225-7377)
(916) 795-3240 (TDD)

For individual continuation coverage, eligibility rules are described under "Individual Continuation of Benefits."

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP code. When you retire from a CalPERS Employer and are no longer working for any Employer, you must select a health plan using your residential ZIP code.

If you use your residential ZIP code, all enrolled Dependents must reside in the health plan's Service Area.

When you use your work ZIP code, all enrolled Dependents must receive all Covered Benefits (except emergency and urgent care) within the health plan's Service Area, even if they do not reside in that area.

Service Area Requirement

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

Living and working outside the WHA Service Area is a material fact that must be reported to WHA by the employer, Subscriber or Member. Note: WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Effective Date of Coverage

Your effective date of health coverage is as follows: Your or your spouse's newborn Child is temporarily covered for thirty (30) days from the date of birth. If the mother is 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 thirtieth (30th) 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.

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.

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

WHA may terminate your membership if the health plan described in this Agreement is discontinued as permitted or required by law. If WHA continues to offer other group 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 groups. If WHA ceases to offer all health care plans in the group 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 CalPERS seeks to renew coverage under the same Group Service Agreement and all Premiums have been properly paid. Premiums may change upon renewal. If your or your dependents' coverage is terminated, you must submit a new application in order to be reinstated.

Termination of Group Service Agreement

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

Individual Continuation of Benefits

If you lose your coverage through your employer group, you may be eligible to continue your benefits through COBRA, Cal-COBRA or HIPAA. Each of these is described in detail below.

For the purposes of COBRA benefits, "spouse" does not include domestic partners.

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

Introduction to COBRA and Cal-COBRA

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

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

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

Under both COBRA and Cal-COBRA, all benefits you receive under continuation coverage are the same as the benefits available to active eligible employees and their eligible dependents. If coverage is modified for active eligible employees and their eligible dependents, it will be modified in the same manner for you and all other Qualified Beneficiaries. In that case, an appropriate adjustment in the Premium for continuation coverage may be made. If your employer's group health plan with WHA terminates before your continuation coverage expires, you may maintain your coverage for the balance of your continuation period as if the group health plan had not terminated as long as, within thirty (30) days of your receipt of notice of the termination, you comply with any requirements that may be imposed regarding enrollment and payment of Premiums resulting from the termination. (See "Normal Period of Cal-COBRA Continuation Coverage" on the following pages.)

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

If you are self-employed and are not covered by a group health plan maintained by an employer with at least two (2) employees, you are not eligible for either COBRA or Cal-COBRA. Certain other people are not eligible to elect continuation coverage under COBRA or Cal-COBRA. See the sections below entitled "COBRA Benefits" and "Cal-COBRA Benefits" for more information about coverage and exclusions.

COBRA Benefits

Your Right to Elect Continuation Coverage. In general, you are entitled to elect federal COBRA continuation coverage if you are a covered employee under your employer's group health plan, or if you are the spouse or dependent child of a covered employee. COBRA benefits also extend to any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. However, small-employer group health plans (generally, fewer than twenty (20) employees) are exempt from COBRA, as are government health plans and church plans. Individuals who move out of the Service Area or no longer work in the Service Area are not eligible for COBRA continuation coverage under WHA.

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

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

Right of your Dependent Spouse & Children to Elect COBRA Continuation Coverage. Your eligible dependent spouse and each eligible dependent child has the separate right to elect continuation coverage upon the occurrence of any of the following Qualifying Events, if written notification is sent to WHA – or to the employer if the employer administers the plan under contract with WHA – not later than sixty (60) days after the date of the Qualifying Event:

1. In the case of your eligible dependent spouse: your spouse may elect continuation coverage, which may include enrolled dependent children, if your spouse's coverage would have ended because of any of the following Qualifying Events:
    a. Your death; or
    b. The termination of your employment for a reason other than your gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or
    c. Your divorce or legal separation from your spouse, or the annulment of your marriage; or
    d. You become entitled to Medicare benefits; or
    e. A dependent enrolled in your group benefit plan loses dependent status.
2. In the case of your eligible dependent Child: your Child may continue coverage for himself or herself if your Child's coverage would have ended because of any of the following Qualifying Events:
    a. Your death; or
    b. The termination of your employment for a reason other than gross misconduct, or the reduction of your work hours (including approved leave without pay or layoff); or
    c. Your divorce or legal separation from your spouse, or the annulment of your marriage; or
    d. You become entitled to Medicare benefits; or
    e. Your eligible dependent child ceases to be an eligible dependent under the rules of the plan.

Cal-COBRA Benefits

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

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

(30) days *prior* to the date your federal COBRA coverage period ends.

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

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

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

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

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

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

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

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

The cost of continuation coverage under both COBRA and Cal-COBRA will include the Premium previously paid by the employee as well

as any portion previously paid by the employer. Under federal COBRA, the rate will be not more than one hundred two percent (102%) of the applicable group coverage rate. Under Cal-COBRA, the rate can be up to one hundred ten percent (110%) of the applicable group coverage rate. Finally, you may be required to pay up to one hundred fifty percent (150%) of the applicable group coverage rate if you are receiving continuation coverage past the eighteen (18) months federal COBRA period due to disability.

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

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

Normal Period of Cal-COBRA Continuation Coverage. Continuation coverage begins on the date of the Qualifying Event and continues for thirty-six (36) months, unless earlier terminated (see "Premature Termination of COBRA or Cal-COBRA" below).

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

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

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

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is comprehensive federal legislation which provides, among other things, portability of health care coverage for individuals changing jobs or who otherwise lose their group health care coverage.

If Subscribers or dependents have questions concerning HIPAA, they may contact Office of Civil Rights at 866.627.7748 or at the following Internet address: www.hhs.gov/ocr/hipaa. To the extent that the provisions of the Group Service Agreement and EOC/DF do not comply with any provision of HIPAA, they are hereby amended to comply.

Termination for Nonpayment

WHA may terminate your membership if the employer fails to pay Premiums due or you fail to make any required contributions toward the cost of coverage. Termination will be effective on the last day of the month following a 30-day notice period. (Example: Your last date of coverage will be December 31st, upon receipt of a 30-day notice dated November 1st)

Exception to Cancellation of Benefits

WHA does not cover any services or supplies provided after termination of the Group Service Agreement or after any Member's coverage terminates. Coverage will end even if a course of treatment or condition began while coverage was in effect. Exceptions are as follows:

1. The Member is Totally Disabled by a condition for which the Member is receiving covered benefits and the Member lost coverage as a result of the termination of the Group Service Agreement. WHA will continue to maintain full coverage during the disabling condition, subject to the prepayment fees and applicable Copayments.

   Coverage will end at the earliest of the following:

   - at the close of the twelfth (12th) month following termination,
   - when it is determined the Member is no longer disabled, or
   - when the Member is covered under a replacement agreement or policy without limitations as to the disabling condition, whichever occurs first.

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

Refunds

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

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.

Medicare Eligibility

If a Member wishes to enroll, it is the Member's responsibility to apply for Medicare coverage once reaching age 65 or otherwise becoming eligible. Please notify WHA promptly if you or any of your covered Dependents become eligible for Medicare.

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. 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 restitution, 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 any claim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third party, including uninsured and underinsured motorist claims, 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.

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.

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.WHA.PERS, 888.877.5378 (TTY), 916.568.0126 (fax), whapers@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 Complaint 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
Phone: 800.368.1019 or 800.537.7697 (TDD)

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

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.

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, 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, provided for in the Group Service Agreement and disclosed in this EOC/DF or in the attached Health Plan Benefits and Coverage Matrix. 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.

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 (or, in the case of a pregnant woman and/or her unborn child) 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).

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

Group Service Agreement means the Group Service Agreement between your employer and WHA.

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

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

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

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

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

Life-Threatening means either or both of the following:

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

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:

1. Is appropriate and necessary for the diagnosis or treatment of the Member's medical condition, in accordance with professionally recognized standards of care;
2. Is not mainly for the convenience of the Member or the Member's Physician or other provider; and
3. 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 Behavioral Health Services, "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 it symptoms, in a manner that is:

- 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 HAI-CA 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 behavioral health 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 a yearly thirty (30) day period as mutually agreed upon by the employer and WHA, 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 Physician means a Physician who, at the time care is provided to a Member, has a contract in effect with WHA or a Contracted Medical Group to provide Medical Services to Members.

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

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.

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 HAI-CA for inpatient and certain non-routine outpatient

Behavioral Health 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 means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

An immediate danger to himself or herself or to others.

Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

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.

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 the attached Health Plan Benefits and Coverage Matrix 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		
Annual Well Visits for Children[3]				x
Annual Well Visits for Men[4]	x			
Annual Women's Well Visits[5]		x		
Aspirin – low dose for the Prevention of Cardiovascular Disease and Colorectal Cancer: Preventive Medication[6]	x	x		
Asymptomatic Bacteriuria, Screening[7]			x	
Autism Screening by PCP[8]				x
Behavioral Counseling in Adults with Cardiovascular Risk Factors	x	x		
Birth Control[9]		x		
Blood pressure screening in children[10]				x
BRCA-Related Cancer in Women, Screening – Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing[11]		x		
Breast Cancer, Preventive Medications		x		
Breast Cancer, Screening[12]		x		
Breastfeeding Support, Supplies and Counseling[13]		x	x	
Cervical Cancer, Screening[14]		x		
Chlamydial Infection, Screening[15]		x	x	
Colorectal Cancer, Screening including Bowel Prep[16]	x	x		
Congenital Hypothyroidism, Screening[17]				x
Dental Caries in Preschool Children, Prevention[18]				x
Depression in Adults, Screening[19]	x	x		
Diet, Behavioral Counseling by PCP to Promote a Healthy Diet[20]	x	x		
Domestic Abuse, Screening and Counseling	x	x		x
Drug Use Screening in Adults 18+, Unhealthy	x	x		
Falls in Older Adults, Counseling, Preventive Medication (Vitamin D) and Other Interventions	x	x		
Folic Acid Supplementation to Prevent Neural Tube Defects, Preventive Medication (Generic Required, Brand Name is Not Covered)[21]		x	x	

Service	Men	Women	Pregnant Women	Children
Gestational Diabetes Mellitus, Screening[22]			x	
Gonorrhea, Ocular Prophylactic Medication[23]				x
Gonorrhea, Screening[24]		x	x	
Group B Streptococcus, Screening			x	
Hearing Loss in Newborns, Screening[25]				x
Hepatitis B Virus Infection in Pregnant Women, Screening[26]			x	
Hepatitis B Virus Infection, Screening – Adolescent, Adult[27]	x	x		x
Hepatitis C Virus Infection, Screening[28]	x	x		x
High Blood Pressure in Adults 18+, Screening	x	x		
HIV, Screening[29]	x	x	x	x
HPV, Screening[30]		x		
Immunizations[31]	x	x		x
Intimate partner violence screening: women of reproductive age[32]		x		
Iron Deficiency – Anemia, Prevention – Counseling by PC[33]			x	x
Latent TB Infection, Screening[34]	x	x		x
Lead, Screening for at-risk children				x
Lipid Disorders in Adults, Screening[35]	x	x		
Lung Cancer, Screening[36]	x	x		
Major Depressive Disorder in Children and Adolescents, Screening[37]				x
Obesity in Adults, Screening[38]	x	x		
Obesity in Children and Adolescents, Screening[39]				x
Osteoporosis, Screening[40]		x		
Phenylketonuria (PKU), Screening[41]				x
Perinatal Depression: Preventive Interventions		x	x	
Postpartum Care			x	
Preeclampsia, Prevention: Low-dose Aspirin[42]			x	
Preeclampsia, Screening			x	
Prenatal, Screening Under the California Prenatal Screening Program[43]			x	
Prevention of HIV Infection: Preexposure Prophylaxis[44]	x	x	x	x
Rh (D) Incompatibility, Screening[45]			x	
Sexually Transmitted Infections, Counseling[46]	x	x		x
Sickle Cell Disease in Newborns, Screening[47]				x
Skin Cancer, Counseling[48]	x	x		x
Statins for the Primary Prevention of Cardiovascular Disease[49]	x	x		
Syphilis Infection, Screening[50]	x	x	x	

Service	Men	Women	Pregnant Women	Children
Tobacco Use in Adults, Counseling and Interventions (Brand Name Medications Not Covered)[51]	x	x	x	
Tobacco Use in Children and Adolescents, Primary Care Interventions[52]				x
Female Sterilization Procedures[53]		x		
Visual Impairment in Children Ages 1 to 5 Years, Screening[54]				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] Children under age 18.

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

[5] Women of all ages.

[6] 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.

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

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

[9] 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.

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

[11] 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.

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

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

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

[15] 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.

[16] Adults aged 45 to 75 years as recommended by your physician.

[17] Newborns.

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

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

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

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

[22] 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.

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

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

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

[26] Pregnant women at first prenatal visit.

[27] Adolescents and adults at increased risk.

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

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

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

[31] 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).

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

[33] 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.

[34] Those at increased risk.

[35] 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.

[36] 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.

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

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

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

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

[41] Newborns.

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

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

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

[45] 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.

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

[47] Newborns.

[48] 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.

[49] 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.

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

[51] 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.

[52] 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.

[53] Includes female sterilization procedures performed in connection with another procedure, such as cesarean delivery. Includes female sterilization procedures performed in connection with an abortion. Female sterilization procedures for contraceptive purposes are not covered if excluded by your plan consistent with Federal law.

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

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