westernhealth ADVANTAGE

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

C1 | 2026

CHANGES FOR 2026

Please make note of the following changes and/or clarifications to the Combined Evidence of Coverage and Disclosure Form for 2026. This list assists members to identify key changes. It is not intended to be a comprehensive list of changes.

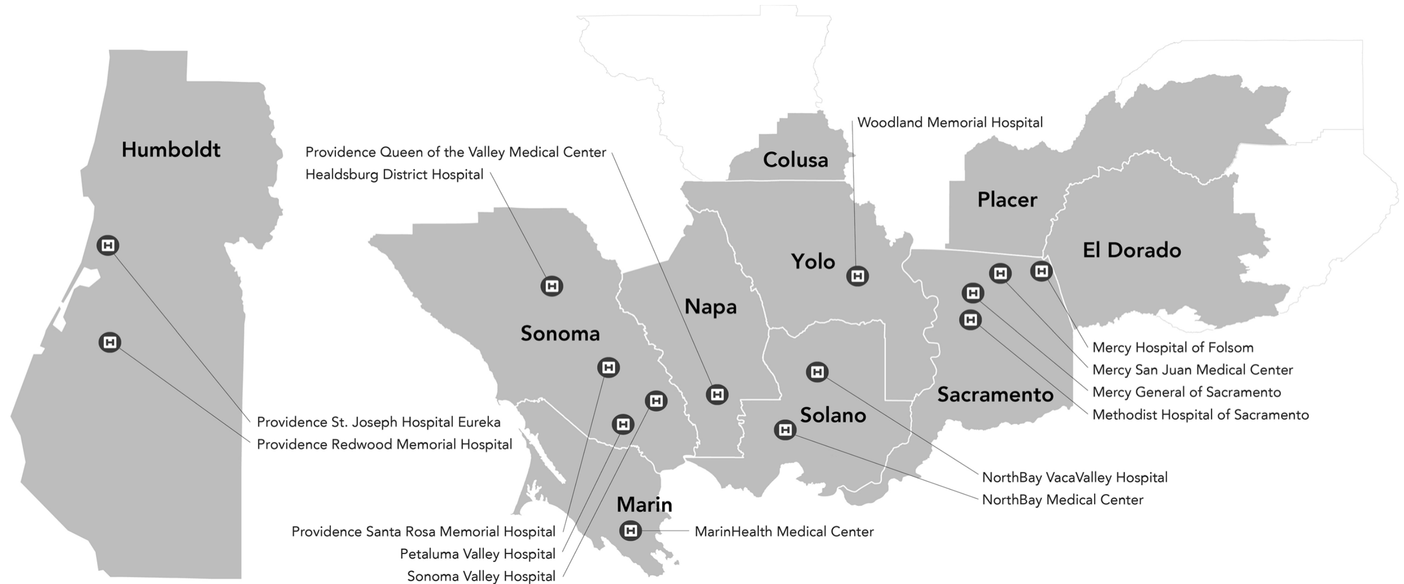
Changes

pp 12-14	Amendment to section “Urgent Care and Emergency Services” to clarify coverage
p 15	Amendment to section “Timely Access to Care” to align with State law
p 20	Amendment to section “Principal Benefits and Covered Services” to update vision care provider
pp 20-24	Amendment to section “Medical Services” to align with State law
pp 26-27	Amendment to section “Other Behavioral Health Services” to align with State law
pp 27-29	Amendment to section “Prescription Medication Benefit” to update pharmacy benefit changes and align with State law
pp 29-35	Amendment to section “Other Health Services” to update benefits and align with State law
pp 34-35	Amendment to section “Other Health Services” to add Doula Services benefit coverage
pp 35-39	Amendment to section “Principal Exclusions and Limitations” to update and/or clarify certain exclusions
p 50	Amendment to section “Other Charges” added a section to align with State law
p 57	Amendment to section “Grievances Related to Vision Benefits” to update contact information for vision care provider
pp 62-69	Amendment to section “Definitions” to include update and/or add new definitions
pp 70-75	Amendment to Appendix A to comply with State and Federal law and updated USPSTF guidance
p 76	Addition of section “Infertility, Fertility, and Family-Building Services” to align with State law

WHA SERVICE AREA

Western Health Advantage Facilities

WHA is contracted with the hospitals and medical centers noted on the map. NOTE: Except for emergent and urgent care, facility services require prior authorization. Your primary care physician (PCP) will coordinate your care.



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

Colusa	partial coverage — 95912
El Dorado	partial coverage — 95613, 95614, 95619, 95623, 95633, 95634, 95635, 95636, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726, 95762
Humboldt	All Zip Codes
Marin	All Zip Codes
Napa	All Zip Codes
Placer	partial coverage — 95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95722, 95736, 95746, 95747, 95765
Sacramento	All Zip Codes
Solano	All Zip Codes
Sonoma	All Zip Codes
Yolo	All Zip Codes

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NOTICE OF LANGUAGE ASSISTANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INTRODUCTION

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

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

This EOC/DF constitutes only a summary of the group health plan. The Group Service Agreement between WHA and your employer that has sponsored your participation in this health plan 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 your employer. An applicant has the right to view the EOC/DF prior to enrollment. You may request a copy of the EOC/DF directly from the plan by calling 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 the employer; shall not invalidate or alter any other provisions; and shall not give rise to any termination rights other than as provided in this EOC/DF.

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

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

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

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

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

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

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

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

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

Confidentiality of Medical Records

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

Public Policy Participation

WHA's Public Policy Committee is responsible for 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:

Western Health Advantage
Attn: Public Policy Committee
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; diagnoses and treatments of fertility (if such services are offered under your plan); or abortion. You should obtain more information before you enroll. Call your prospective doctor, Medical Group, independent practice association or clinic, or call WHA's Member Services Department at the number listed below to ensure that you can obtain the health care services that you need.

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

Liability of Member for Payment

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 and/or deductible.

Participating Providers

All non-Urgent Care and non-Emergency Care must be provided by your PCP, his/her on-call Physician or a Participating Provider referred by your PCP, with the exception of obstetrical and gynecological services, Mental Health and Substance Use Disorder

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

Non-Participating Providers

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

Note: You must present your WHA ID card and coverage information to all providers before obtaining services, including when services will be rendered outside of the WHA Service Area.

Grandfathered Status Under Federal Health Care Reform

This group health coverage may be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). The employer that has entered into the Group Service Agreement under which WHA provides this coverage to Subscribers and their eligible dependents is the party that will determine whether to maintain this plan as grandfathered or not.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your employer's plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Regardless of grandfathered status, your Western Health Advantage coverage has no cost-sharing on preventive services and will provide you most if not all consumer protections in the Affordable Care Act.

For information regarding which protections apply and which protections do not apply to a grandfathered health plan, go to www.dol.gov/ebsa/pdf/grandfatherregtable.pdf. For information concerning what might cause a plan to change from grandfathered health plan status, go to www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

HOW TO USE WHA

Selecting Your Primary Care Physician

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

should be received from your PCP or other Participating Provider as referred by your PCP.

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

The types of PCPs you can choose include:

- pediatricians and pediatric subspecialists (for children)*,
- family practice physicians,
- internal medicine physicians (some have a minimum age limit)*,
- general practice physicians, and
- obstetrician/gynecologists*.
- ***Note:** Not all internal medicine physicians, pediatricians, pediatric subspecialists and obstetrician/gynecologists are designated PCPs. Some may practice only as Specialist Physicians. Visit westernhealth.com to search for PCPs in your preferred specialty.

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

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

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

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

Changing Your Primary Care Physician

Since your PCP coordinates most of your Covered Services, it is important that you are completely satisfied with your relationship with him or her. If you want to choose a different PCP, call Member Services **before** your scheduled appointment. Member Services will ask you for the name of the Physician and your reason for changing. **Note:** Generally, Members aged 18 and older are responsible for submitting their own PCP change requests (an adult family member must have an authorization on file, signed by members over 18 years of age, to submit the request on their behalf.).

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

Transferring to Another Primary Care Provider or Medical Group

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

- If your requested PCP is in the same Medical Group as your existing PCP, you may request to transfer to your new PCP effective the first of the following month.
- If your requested PCP is in a different Medical Group than your existing PCP, you may request to transfer to the new PCP effective the first of the following month unless you are confined to a Hospital, in your final trimester of pregnancy, in a surgery follow-up period and not yet released by the surgeon, or receiving treatment for an acute illness or injury and the treatment is not complete.
- Except as described below, PCP changes are always effective the first of the month following

the request, and may not be changed retroactively:

- If you were "auto-assigned" to a PCP and you notify WHA within 45 calendar 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.

If you change Medical Groups, existing referrals and/or Authorizations are no longer valid and you must obtain a new referral from your new assigned PCP or Authorization from your new Medical Group.

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 faxed authorization, which is sufficient along with WHA your ID card.

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

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

Advantage Referral

In order to expand the choice of physician specialists for you, WHA implemented a unique program called "Advantage Referral." The Advantage Referral" program allows you to access **some of the Specialist Physicians within your network (as listed in the Provider Directory),** instead of limiting your access to those specialists who have a direct relationship with your assigned 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. The initial referral from your PCP allows for one consultation, plus 2 follow-up visits, and includes routine labs, basic office diagnostics, and plain x-rays. Anything beyond this initial referral will require a prior authorization. You may request to be referred to any network specialists who participates in the Advantage Referral program. The WHA Provider Directory will indicate if the provider participates in the Advantage Referral program, or you may call 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.
- MHSUD: See the back of your WHA ID card for the telephone number for your MHSUD benefits provider or visit mywha.org/bh.
- Gynecology Examination/Obstetrical Services
- Vision: An annual eye exam (when covered under your health plan benefits)
- 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, you may call your PCP at any time of the day, including evenings and weekends.
- Services or items to mitigate diseases declared during a public health emergency.
- Acupuncture and chiropractic services.

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

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

Prior Authorization

Certain Covered Services require Prior Authorization from WHA or its Medical Group in order to be covered. Your PCP must contact the 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 if the requested services are to be performed with a non-Participating Provider and a Participating Provider is available to supply the Medically Necessary services.

Prior Authorization is required for:

- Services from non-Participating Providers except in Urgent Care situations arising outside WHA's Service Area or Emergency situations. For example, a Covered Service may be Medically Necessary but not available from Participating Providers, or a Participating Specialist, MHSUD Provider, acupuncturist or chiropractor may not be geographically accessible. Then, your Physician must request Prior Authorization from WHA or its delegated Medical Group and obtain approval before you receive services from a non-Participating Provider;
- Care with a Specialist Physician that extends beyond an initial number of visits or treatments;
- Physical therapy, speech therapy and occupational therapy;
- Rehabilitative services (cardiac, respiratory, pulmonary);
- All hospitalizations;
- All surgeries (except surgeries performed to stabilize an emergency medical condition);
- Non-emergent medical transport or ambulance care;
- Second medical opinions;
- Some prescription medications (if prescriptions are covered under your plan, prescription medication prior authorization requests are completed within 72 hours for routine requests and 24 hours for urgent requests);
- All infertility or fertility services (if such services are offered 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
- MHSUD inpatient, residential treatment, and non-routine outpatient services including outpatient electroconvulsive therapy, intensive outpatient program, partial hospitalization program, psychological testing, repetitive transcranial magnetic stimulation, and Behavioral Health Treatment for Autism Spectrum Disorder including Applied Behavioral Analysis (ABA).
- Requests for Prior Authorization will be authorized or denied within a timeframe appropriate to the nature of your 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 you, a practitioner on your behalf or a representative for you will be reviewed and determined within seventy-two hours of receipt if a later determination could be detrimental to the life of your health, or could jeopardize your ability to regain maximum function, or in the opinion of a physician with knowledge of your 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 you and the Provider requesting the Authorization of the needed information and the anticipated date on which a decision may be rendered. Any Prior Authorization is conditioned upon you being enrolled and remaining eligible for the period that the Covered Services are received. If you are not properly enrolled or if coverage has ended at the time the services are received, you 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 applicable Charges. You and your Physician will receive written notice of authorized or denied services. 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

You may request a second medical opinion regarding any diagnosis and/or any prescribed medical procedure. You 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 your PCP. You may also contact WHA's Member Services Department at the number listed below for assistance or for additional information regarding second opinion procedures. Decisions regarding second medical opinions will be authorized or denied within the following timelines:

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

Urgent Care and Emergency 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 Copayment Summary for the applicable Copayments and/or Deductible for emergency room visits and Urgent Care facility visits.

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

If an Urgent Care situation arises while you are outside of WHA's Service Area, WHA will reimburse a non-Participating Provider for Covered Medical Services to treat the Urgent Care situation, less the applicable Copayment. If you have an Urgent Care situation in WHA's Service Area, you may contact your PCP's office for direction about where to go for Urgent Care treatment within the contracted network and whether telehealth options are available. You may also contact WHA's nurse advice line by calling 888.656.3574 or WHA Member Services for assistance.

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, you may call your PCP. You can call your doctor at any time of the day, including evenings and weekends or call WHA's nurse advice line by calling 888.656.3574. Explain your condition to your doctor, the Physician on call at your doctor's office, or the nurse on the nurse advice line and he/she will advise you. In the event you are not able to reach your Physician or the nurse advice line, you may go to an Urgent Care facility affiliated with your Medical Group. For more information about the nurse advice line, please see "Principal Benefits and Covered Services," "Other Health Services."

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

Post-Stabilization Care

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

Follow-Up Care

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

Call your PCP for all follow-up care. Please note that referrals obtained from an emergency room physician is not a valid referral. 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

- **Urgent Care**
  - Prior authorization not required: 48 hours
  - Prior authorization required: 96 hours
- Visit For Non-Urgent Care
  - Primary Care Physician: 10 business days
  - Specialty Care Physician: 15 business days
  - Mental Health Appointment (non-physician): 10 business days
    - Includes counseling professionals, substance abuse professionals and qualified autism service providers
  - Ancillary Provider: 15 business days

- Includes lab work or diagnostic testing, such as mammogram or MRI, or treatment such as physical therapy.

- **Follow-Up Care**
  - Mental Health/Substance Use Disorder (non-physician): 10 business days from prior appointment
- **Telephone triage and screening services with a health professional**
  - Routine/Urgent: Waiting time cannot exceed 30 minutes
  - WHA members can reach the Fonemed nurse advice line 24 hours per day, 7 days per week, 365 days per year by calling 888.656.3574.
- **Speaking with a WHA member service representative by phone during normal business hours**
  - Waiting time cannot exceed 10 minutes

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).

Appointment Availability with Nurse Practitioners or Physician’s Assistants: Please note that if your PCP or specialist is not available for an appointment within required timely access standards, you may be scheduled an appointment with a nurse practitioner and/or physician’s assistant instead. If you decline the appointment with a nurse practitioner and/or physician's assistant, this may result in a delay in your care.

If You Need Help Obtaining Timely Care

If you need help obtaining timely care:

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

Cultural and Linguistic Services

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

If you need assistance in a language other than English, your doctor’s office and WHA offers interpretation services in many languages, including Spanish and American Sign Language. Let your physician’s office know when you call for an appointment. View the Notice of Language Assistance for more information and assistance from

Member Services. The deaf and hard of hearing may use their provider's or WHA's TTY line at 711.

Interpreter services are also available upon request by calling 877.793.3655. You can chat with a nurse by visiting mywha.org/nurseadvice. Additional information about access to care and how to obtain a referral or prior authorization is available at mywha.org/planbasics and your EOC.

Provider Network Adequacy

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

Direct Access to Qualified Specialists for Women's Health Services

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

Access to Specialists

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

Transition of Care and Continuity of Care

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

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

- Care of a newborn child whose age is between birth and thirty-six (36) months (care continued for a period not to exceed twelve [12] months).
- Performance of surgery or other procedure that has been authorized by WHA or the Medical Group as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

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

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 notify you of the provider's termination and require a non-Participating Provider whose services are continued pursuant to this section for a newly covered Member to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers of similar services who are not capitated and who are practicing in the same or a similar geographic area as the non-Participating Provider, including but not limited to credentialing, hospital privileging, Utilization Review, peer review and quality assurance requirements. 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 Member Services Department prior to enrollment, within thirty (30) days from the Effective Date of your WHA coverage or from the date your provider terminated with WHA to request a Continuity of Care form. Continuity of Care requests received more than thirty (30) days from the Effective Date of your WHA coverage or from the date your provider terminated with WHA will be evaluated by WHA's Medical Director or delegate. You also may go to WHA's web page, westernhealth.com, to obtain a copy of the Continuity of Care form. Complete and return this form to WHA as soon as possible. After receiving the completed form, WHA will notify you if you qualify for continuity of care with your provider. If you do qualify for continuity of care, you will be provided with the appropriate plan for your care. If you do not qualify, you will be notified in writing and offered alternative Participating Providers. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis. To request a copy of our continuity of care policy, please call our Member Services Department 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 Member Services Department at the number listed below, Monday through Friday, 8 a.m. to 6 p.m.

Please note: You should not continue care with a non-Participating Provider without WHA's or your

Medical Group's approval. If you do not receive this approval in advance, payment for services performed by a non-Participating Provider will be your responsibility.

Access to Emergency Services

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

MEMBERS' RIGHTS AND RESPONSIBILITIES

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.

- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
  - Your Plan or Health Care Provider.
  - Any care you receive, or access to care you seek.
  - Any covered service or benefit decision that your Plan makes.
  - Any improper charges or bills for care.
  - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
  - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.

- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

PRINCIPAL BENEFITS AND COVERED SERVICES

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

- Your PCP
- A Participating Specialist Physician when your PCP gives you a referral (first three visits need a referral only – additional visits require Prior Authorization - see “How to Use WHA” “Prior Authorization”)
- Other Participating Providers, when your PCP gives you a referral
- Participating or non-Participating Providers who have been authorized by your Medical Group or USBHPC (see “How to Use WHA” “Prior Authorization”)
- A participating OB/GYN within your Medical Group or outside of your Medical Group if the OB/GYN participates in Advantage Referral (see “How to Use WHA” “Referrals to Participating Specialists”)
- A VSP Vision Care (“VSP”) Advantage Participating Provider providing your annual eye exam
- A USBHPC Participating MHSUD Provider (see “How to Use WHA” and “Prior Authorization”)
- WHA covers Emergency Care services as described under the section titled “How to Use WHA,” in the subsection “Urgent Care and Emergency Services.”

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

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

Medical Services

Outpatient Services

WHA covers the following outpatient services, subject to the applicable cost-sharing:

- Office visits for adult and pediatric care, well-baby care, and immunizations
- Prenatal maternity care including coverage for prenatal diagnosis of genetic disorders of the fetus, coverage RhoGAM shot for Rh negative moms, coverage for tests for specific genetic disorders for which genetic counseling is available, high-risk pregnancy ultrasounds, diphtheria, tetanus, and acellular pertussis (Tdap) booster vaccine, and coverage for testing under the state of California Prenatal Screening Program
- Postnatal maternity care (to optimize the health of women and infants, the American College of Obstetricians and Gynecologists (ACOG) currently recommends that all women have contact with their obstetrician-gynecologist or other obstetric care provider, either via e-mail, telephone, or in-person visit, within the first three weeks postpartum), including comprehensive postpartum visit(s)

- Maternity mental health screenings, including at least one maternal mental health screening conducted during pregnancy, at least one additional screening conducted during the first six weeks of the postpartum period, and additional postpartum screenings if medically necessary.
- 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) through a VSP Advantage Participating Provider. If your employer has elected to purchase additional vision services, please see the attached benefit summary rider for details.
- 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
- 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
- Limits on Rehabilitative and Habilitative services will not be combined.
- Fertility preservation for members who will be undergoing a medically necessary treatment that can result in infertility.

Note: Even if you stay in the 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.

Preventive Services and Immunizations: Appendix A lists Preventive Services and Immunizations covered by WHA, and includes services and immunizations that are required to be covered by law. Preventive Services and Immunizations are covered with no copayment or cost sharing. WHA uses the recommendations of the United States Preventive Services Task Force (USPSTF) to establish Preventive Services benefits. Items rated A or B by the USPSTF for the member seeking services are generally covered and listed in Appendix A. The USPSTF recommendations are available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

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 a complete list of recommended immunizations at https://www.cdc.gov/vaccines/vpd/vaccines-age.html.

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

Note on Immunizations: In addition to the coverage described in this section, your Medical Group may reimburse for preventive vaccines required by state and federal law, including annual influenza and COVID-19 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. These vaccines may also be obtained at a Participating Retail Pharmacy.

For an office visit to be considered “preventive,” the service must have been provided or ordered by your PCP, or Participating OB/GYN within your Medical Group (or who participating in Advantage Referral). In addition, the primary purpose of the office visit must have been to obtain the preventive service. In the event you receive additional services that are not part of the preventive exam (for example, procedures or labs resulting from screenings or in response to your medical condition or symptoms), you will be responsible for the cost of those services as described in your Copayment Summary. WHA and its Medical Groups manage your care by limiting the frequency, method, treatment or setting for Preventive Services and Immunizations.

WHA does not cover any medications or supplements that are generally available over the counter except for folic acid and aspirin in certain circumstances, and FDA approved contraceptives described under the heading “Family Planning”. This applies even if you have a Prescription for the item. Refer to Appendix A for more detail. Your plan may provide additional preventive services at no cost to you; consult your Copayment Summary for more information.

Family Planning: WHA covers all FDA-approved contraceptive drugs, devices, and other products, including those products available over the counter, as prescribed by the Member’s provider. This includes clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, and follow-up including, but not limited to, managing side effects, ensuring adherence, and services related to device removal.

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

- Birth control pill
- Birth control patch
- Birth control injection
- Birth control implant
- Birth control sponge
- Female condoms
- Spermicide
- Diaphragm
- Cervical cap
- Emergency contraception pill
- Vaginal contraceptive ring
- Intra-uterine device (IUD)
- Sterilization procedures
- Sterilization implant

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

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

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

Breastfeeding Support: WHA covers counseling and supplies, during pregnancy and postpartum. This includes breast pump purchase or 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:

- A cervical cancer screening test (including a conventional Pap smear test and a human papillomavirus screening test that is federal Food and Drug Administration (FDA) approved, upon referral by the Member's Physician, nurse practitioner, or certified nurse midwife
- 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 otherwise apply to Covered Services.

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

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

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

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

PANDAS/PANS: WHA covers medically necessary prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by your Provider. Coverage for PANDAS and PANS will not be subject to cost sharing that is greater than that applied to other benefits.

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 the treating Physician
- Hospital specialty services including:
  - The use of the operating room and the recovery room
  - Anesthesia

- Inpatient drugs
- X-rays
- Laboratory services
- Radiation therapy
- Enteral formula for Members requiring tube feeding
- Nursery care for newborns

- Medical, surgical and cardiac intensive care
- Blood transfusion services
- Rehabilitative services including physical therapy, speech therapy and occupational therapy (if Medically Necessary and required incident to an admission for Covered Services)
- Respiratory therapy, cardiac therapy and pulmonary therapy (if Medically Necessary and required incident to an admission for Covered Services)

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

Please refer to your Copayment Summary for copayment and/or Deductible responsibility.

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

- You are an inpatient starting when you are formally admitted to a hospital with a doctor's order. Your Emergency Room Copayment is waived if you are admitted as an inpatient.
- You are an outpatient if 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.

Mental Health and Substance Use Disorder Services

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

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If WHA fails to arrange for those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive

services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1.888.466.2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

All Utilization Review determination criteria and any education program materials are available upon request at no cost.

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, psychiatric health facility, or other inpatient facility. Inpatient services include psychiatric observation for an acute psychiatric crisis. Inpatient Services require Prior Authorization by USBHPC.

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.

a. **Office visits** include, but are not limited to, mental health individual and group evaluation and therapy.

b. **Outpatient other services** include intensive outpatient program (such as intensive community-based or home-based treatment), partial hospitalization/day treatment and outpatient electroconvulsive therapy, behavioral health treatment for autism, repetitive transcranial magnetic stimulation, psychological and neuropsychological testing, and non-emergency psychiatric transportation.

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

BHTABA must be administered by:

- A qualified autism service provider, or
- A qualified autism service professional supervised by a qualified autism service provider, or
- A qualified autism service paraprofessional supervised by a qualified autism provider or qualified autism service professional.
- Outpatient laboratory tests and X-rays are also covered when prescribed by a licensed psychologist to (i) diagnose and/or rule out an ASD condition or (ii) guide management of a medication for an ASD condition.

BHT/ABA requires prior authorization by USBHPC.

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

Substance Use Disorder Services

A. *Inpatient*
Inpatient services for evaluation and care for substance use dependency, including rehabilitation and withdrawal management (as described in the most recent version of the

American Society of Additional Medication (ASAM) Criteria, are covered. This benefit includes detoxification services. Services require Prior Authorization by USBHPC and must be provided at a participating facility including Residential Treatment Center.

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.

a. **Office visits** include, but are not limited to, substance use disorder individual and group counseling, medical treatment for withdrawal symptoms, and substance abuse disorder methadone maintenance treatment.

b. **Outpatient other services** include psychological and neuropsychological testing, intensive outpatient program, partial hospitalization/day treatment, office-based opioid treatment, and substance use disorder outpatient detoxification.

Residential recovery services are covered with Prior Authorization by USBHPC.

Methadone maintenance treatment is covered by USBHPC.

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

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

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

Other Behavioral Health Services

The following behavioral health services are also covered:

1. Medically necessary treatment of a MHSUD condition, including behavioral health crisis services provided to a member by a 988 center or mobile crisis team, is covered and does not require prior authorization. Whether these services are provided by a Participating or non-Participating Provider, your only liability is the applicable copayment and/or deductible.

   Non-Participating providers are prohibited under state law from billing you more than your applicable copayment and/or deductible for these services. If you are billed more than your applicable copayment and/or deductible for such services provided by a non-Participating provider, you may report the provider to the California Department of Managed Health Care by calling 888.466.2219 or by contacting Member Services at the number listed below for assistance.

2. The Community Assistance, Recovery, and Empowerment (CARE) Court Program authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan to treat adults (those over 18 years of age) who are currently experiencing a severe mental illness and have a diagnosis within the schizophrenia spectrum or other psychotic disorders, who meets certain criteria. Health care services provided to a member pursuant to a court-approved CARE agreement or a CARE plan (which may include, but is not limited to, stabilization medication) is covered and does not require prior authorization (other than prescription drugs).
3. Coordinated specialty care for the treatment of first episode psychosis.
4. Laboratory services for the diagnosis or treatment of a behavioral health condition.
5. Schoolsite services for a mental health condition or substance use disorder that are delivered to a member at a schoolsite pursuant to section 1374.722 of the California Health & Safety Code.

6. Educational services, including but not limited to, for employment or professional purposes, are covered when Medically Necessary to treat mental health and substance use disorders.
7. Marriage counseling is covered for treatment of a behavioral health condition.
8. Maternity mental health screenings, including at least one maternal mental health screening conducted during pregnancy, at least one additional screening conducted during the first six weeks of the postpartum period, and additional postpartum screenings if medically necessary.

Prescription Medication Benefit

WHA covers Prescription Medications as described in this EOC/DF. Other drugs, medications, and related items are covered only if set forth in this EOC/DF. WHA has contracted with Optum Rx, Inc. ("Optum Rx") to administer the outpatient Prescription Medication benefit on behalf of WHA. Optum Rx administers the retail pharmacy and mail order pharmacy programs; delivery of specialty pharmacy products, including self-injectable medications; clinical pharmacist consultation; and clinical collaboration with your provider to ensure you receive the appropriate care.

Prescription Medications that are covered by WHA are listed on its formulary. The formulary is subject to change any time throughout the year and you will receive prior notice of any such changes if it impacts a medication you are taking. Some Prescription Medications will continue to be covered even when not on the formulary (see "Continuity Drugs" and "Formulary Exceptions Process").

You can obtain a copy of WHA's formulary by visiting westernhealth.com or contacting the WHA Member Services phone number listed below. Please note that the presence of a drug on WHA's formulary does not guarantee that you will be prescribed that drug by your prescribing provider for a particular medical condition.

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

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

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

Generic Medications are required. The pharmacist may automatically substitute an equivalent Generic Medication for the prescribed Brand Name Medication unless your physician writes "do not substitute" or "prescribe as written," or there is not a Generic equivalent available. In these cases, the Member will be provided the Brand Name Medication as written by the Member's Physician, even if a Generic is available. The Brand Name Copayment will apply. Regardless of Medical Necessity or Generic availability, you will be responsible for the Brand Name Copayment when a Brand Name Medication is dispensed. If a Generic Medication is available and you elect to receive a Brand Name Medication without medical indication from the prescribing Physician, you will be responsible for the difference in cost between Generic and Brand Name in addition to copayment specified on your Copayment Summary. The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum. In addition, if there is a maximum copayment applicable to prescription medications listed on your Copayment Summary, that limit does not apply when you elect to receive a Brand Name Medication without medical indication.

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

Optum Rx's Smart Fill program allows members to obtain less than a 30-day supply for a prorated

Copayment. Only certain medications are available under the Smart Fill program. Medications obtained under the Smart Fill program may only be obtained at a pharmacy of a WHA-contracted hospital or medical group pharmacy or through Mail Order. To determine whether your prescribed medication is available under the Smart Fill program, call Member Services.

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

Formulary/Preferred Drug List

WHA's formulary is a Preferred Drug List (PDL) with a Four-Tier Copayment Plan. The four tiers are: Tier 1, Tier 2, Tier 3 and Tier 4. Tier 1 Medications are covered at the lowest Copayment level. Tier 2 Medications are provided at the second Copayment level. Tier 3 Medications are covered at the third tier Copayment level. Tier 4 Medications are covered at a percentage copayment basis (refer to your Copayment Summary for details). There are a number of drugs, regardless of tier level that may require Prior Authorization to ensure appropriate use based on criteria set by the Pharmacy and Therapeutics (P&T) Committee. Please note that a drug's presence on the PDL does not guarantee that the Member's Physician will prescribe the drug. Members may request a copy of the PDL by calling the number listed below or view the document on our web site, westernhealth.com.

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

Formulary Exceptions Process

Drugs not listed on the formulary may be covered if WHA approves an exception request. To submit an exception request, please contact your Participating Provider. Your Participating Provider will need to submit a prior authorization request on your behalf for the drug you are seeking a formulary exception.

Continuity Drugs

If WHA moves to exclude a drug that was previously covered and provided to a member, WHA will continue to provide the drug as long as it was previously approved by WHA and continues to be prescribed by the prescribing provider, and the drug is appropriately prescribed and is safe and effective for the member's medical condition, as required by law.

Maintenance Medications

Maintenance Medications are commonly used in the treatment of chronic conditions (like arthritis, high blood pressure, heart conditions and diabetes), and are usually administered continuously rather than intermittently. Up to a 100-day supply of Maintenance Medications may be obtained by mail order through Optum® Home Delivery or up to a 90-day supply at a Participating Retail Pharmacy. Oral contraceptives are also available through the mail order program. You can request the order form and brochure for this benefit by contacting Optum Rx Customer Service at 844.568.4150, 24 hours a day, 7 days a week (except Thanksgiving and Christmas) or online at westernhealth.com/pharmacy-information.

Specialty Medications

Specialty Medications are only available via mail order through Optum® Specialty Pharmacy. Specialty medications are generally Tier 4, except for certain limited circumstances. You can order prescriptions online at westernhealth.com/pharmacy-information, or by contacting Optum Rx Customer Service at 844.568.4150. WHA may approve requests to fill specialty medication prescriptions at Participating Retail Pharmacies in urgent situations.

Note: Your ability to purchase mail order medications may be suspended if there is an outstanding balance on your account.

Covered Prescription Medications

- Self-administered medications that require a Prescription by state or federal law, written by a Participating Provider, or a pharmacist if allowed by law and dispensed by a Participating Retail Pharmacy
- Compounded Prescriptions for which there is no FDA approved alternative and which contain at least one Prescription ingredient. Compounded Prescriptions may be subject to Prior Authorization.
- Insulin and insulin syringes with needles, glucose test strips and tablets
- Oral contraceptives and diaphragms
- An early refill of Prescription Medications, when a member cannot access a Participating Retail Pharmacy, for a member's vacation is allowed once per year for a 30-day supply. To request, please contact the Optum Rx Pharmacy Help Desk at 844.568.4150, 24 hours a day, 7 days a week (except for Thanksgiving and Christmas)
- Prescription and OTC smoking cessation products are available up to a 90-day supply with no cost-sharing when prescribed by a Participating Provider, for up to two (2) cycles of smoking cessation attempts per year
- HIV preexposure and postexposure prophylaxis that is furnished by a pharmacist is covered, including the pharmacist's services and related testing ordered by the pharmacist.

COVID-19 Products

- WHA covers COVID-19 vaccinations with no cost-sharing when provided at a Participating Retail Pharmacy or through a Participating Provider.
- COVID-19 medications are covered with no cost-sharing when obtained through a Participating Retail Pharmacy or Participating Provider.
- WHA will reimburse members for the cost of up to eight (8) FDA-approved at-home COVID-19 test kits per month at a maximum reimbursement of $12 per kit (including tax and shipping if applicable) when obtained at a Participating Retail Pharmacy.

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

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

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

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

Other Health Services

Home Health Care Services, including treatment for a mental health condition or substance use disorder, are covered when prescribed by a Participating Provider and determined to be Medically Necessary. Home Health Care Services consist of part-time intermittent care provided at the Member's home in place of a continued acute hospitalization. Up to one hundred (100) visits per calendar year are covered, except when Medically Necessary to treat a mental health condition or substance use disorder. "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

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).

Part-time skilled nursing services and home health aide services are those furnished any number of days per week, provided that the skilled nursing services and home health aide services, combined, are furnished less than eight (8) hours per day and 35 hours per week.

Home Self-Injectable Medications are covered regardless of whether you have Prescription coverage. These are injectable drugs that you or your caregiver can safely self-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 benefits for the terminal illness under your plan, while the hospice election is in effect. 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 cover 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 WHA guidelines, obtained from a contracting WHA pharmacy
- Durable Medical Equipment in accordance with Plan guidelines
- Short-term inpatient care including respite care, care for pain control and acute and chronic symptom management
- Counseling and bereavement services

Skilled Nursing Facility, care to a maximum of one hundred (100) days in each Benefit Period is covered if Medically Necessary. A Benefit Period begins on

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

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

Examples of DME includes the following items that are medical in nature: 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.
- DME, Prosthetic Devices and Orthotic Devices are limited to one device for each body part and one piece of equipment that serves a function.

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 either improve function, or to create a normal appearance, to the extent possible. Dental care that is integral to reconstructive surgery for cleft palate is covered.

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

Mastectomy and Reconstructive Breast Surgery to restore and achieve symmetry following a mastectomy is covered. Members who elect to have breast reconstruction after a mastectomy are covered for all complications of the mastectomy and follow-up reconstructive surgery, including Medically Necessary physical therapy to treat 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 following a mastectomy is also covered if, in the opinion of the attending Physician, this surgery is necessary to achieve normal symmetrical appearance. Your attending Physician will work with you to determine the length of the hospital stay for mastectomies and lymph node removals.

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

- A lifetime limit of two cycles of egg retrieval (including ovarian stimulation as needed)
- A lifetime limit of two cycles of sperm collection
- A lifetime limit of up to two attempts of embryo creation. WHA will not cover any costs

associated with the retrieval of gametes from anyone other than the Member undergoing the medical treatment that may cause iatrogenic infertility

- A lifetime limit of up to two attempts to retrieve gonadal tissue
- Cryopreservation and storage of eggs, embryos, or sperm as follows:
  - Until the Member reaches age 26 for Members who are under the age of 18 on the date the Member's genetic material is first cryopreserved.
  - Until the Member reaches the age of 26 or for three years, whichever period is longer, for a Member who is 18 years or older but not yet 26 years old on the date the Member's genetic material is first cryopreserved.
  - For the period of three years for a Member who is 26 years or older at the time of the Member's genetic material is first cryopreserved.

"Lifetime" in this section refers to any attempts, treatments or services rendered during the Member's coverage under a WHA plan at any time during the Member's lifetime.

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

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

Note: This benefit covers fertility preservation services only, and does not include future implantation, or testing or treatment of infertility.

Testing and treatment of PKU includes formula and special food products that are prescribed and are Medically Necessary for treatment of PKU, or when Medically Necessary to treat mental health and substance use disorders.

Transplants are covered if ordered a Participating Physician and approved by WHA's Medical Director in advance, subject to the terms of this EOC/DFDF. 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.

Diabetic supplies, equipment, and services for the treatment and/or control of diabetes are covered. Services include self-management training, education and medical nutrition therapy necessary to enable you to properly use 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 items are covered and available under your Prescription Medication benefit:

- Testing strips
- Lancets
- Insulin syringes

Pasteurized donor human milk is covered when Medically Necessary and obtained from a tissue bank licensed by the State Department of Public Health.

Pediatric Asthma supplies, equipment, and services are covered when Medically Necessary for the management and treatment of pediatric asthma. This includes coverage for outpatient self-

management training education to enable you to properly use the prescribed equipment, supplies and medications. The following equipment and supplies are covered for pediatric asthma, even if the items are available without a prescription:

- Nebulizers, including face masks and tubing
- Inhaler spacers
- Peak flow meters

Acupuncture and chiropractic care, including acupressure, are covered through Landmark Healthplan of California, Inc., a Knox-Keene licensed specialty plan, unless excluded. If your plan includes Acupuncture or Chiropractic benefits, additional detail will appear on your Copayment Summary. For full disclosure of benefit coverage, please see the Landmark EOC and benefit summary information included with this EOC/DF and/or available at westernhealth.com under Personal Access. 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.

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

Emergency room medical care and follow-up health care treatment are covered when provided to a member following a rape or sexual assault. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault. These services are provided without any cost-sharing for the first nine (9) months after a Member initiates treatment.

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 mywha.org/CM and log into your MyWHA account.

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 years and older
- Cardiac Disease Program for Members 18 years and older
- Congestive Heart Failure (CHF) program for Members 18 years and older
- Coronary Artery Disease (CAD) program for Members 35 years and older
- Chronic Obstructive Pulmonary Disease (COPD) for Members 40 years and older
- Diabetes Program for Members 6 years and older.

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

Nutritional Counseling for weight management is covered for individuals meeting specified medical criteria, as ordered by your PCP or a Participating Physician, and prior authorized.

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

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

- Caring for minor injuries and illnesses
- Seeking the most appropriate help based on the medical concern, including help for behavioral health concerns
- Identifying and addressing emergency medical concerns, including help for MHSUD concerns
- Preparing for doctor visits
- Understanding prescription medications
- Helping with lifestyle choices to improve health
- Providing education and support regarding decisions about tests
- They can also help you get the appropriate care you need with the right WHA health care providers, including referrals to urgent care centers or hospital emergency rooms as necessary.

Note: Interpreter services are available. For relay assistance services, please call 888.563.2250 (Voice/TTY/ASCII) or 711 (TTY Operator Services).

Biomarker testing, as prescribed, is covered when Medically Necessary, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member’s disease or condition to guide treatment decisions. Biomarker testing is subject to Utilization Review, except that biomarker testing for cancer progression or recurrence in a Member with advanced or metastatic stage 3 or 4 cancer does not require prior authorization.

Gender Dysphoria: WHA covers Medically Necessary transgender care and services for members with gender dysphoria. Gender reassignment surgery is one treatment option for Gender Identity Disorder (GID). 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 8.

Polysomnography (sleep study) is covered when addressing sleep disorders such as sleep apnea, narcolepsy, or other sleep-related issues and disorders, or as Medically Necessary. Sleep studies may be used to evaluate members and effectiveness of treatment for certain conditions that are considered comorbid conditions with sleep disorders, such as insomnia, restless leg syndrome, depression, and anxiety. Sleep studies may also be used to evaluate and assess the impact of substance use disorders on sleep architecture.

Routine foot care (e.g., treatment of or to the feet for corns or calluses) is covered when Medically Necessary.

Smoking cessation Medications are covered when Medically Necessary.

Services and supplies associated with the donation of organs are covered when the recipient is a member of WHA.

Weight control surgery or procedures (e.g., gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction and HCG injections) are covered when Medically Necessary as determined by WHA with Prior Authorization for the treatment of morbid obesity.

Personality reorganization diagnosis and treatment is covered when Medically Necessary to treat mental health and substance use disorders.

Treatment of short stature is covered when Medically Necessary and the recipient meets specified criteria.

Doula services are covered and include health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including

support during miscarriage, stillbirth, and abortion. Services can be provided virtually or in person with locations in any setting, including, but not limited to, homes, office visits, hospitals, or alternative birth centers. Coverage includes up to twelve (12) visits as follows:

- Initial visit
- Up to 8 prenatal or postpartum visits
- Support during labor and delivery (including labor and delivery ending in stillbirth), miscarriage, and abortion
- Up to 2 extended three-hour postpartum visits

Coverage includes one type of visit per day, per member. Additional visits require Prior Authorization.

Members can contact WHA Member Services for questions on how to access doula services. Members can also obtain doula services with a provider of their choice and submit the receipt to WHA for reimbursement up to $1,500.

Infertility and fertility diagnosis and treatment services are covered if such services are offered under your plan (please see the attachment entitled “Infertility, Fertility and Family-Building Services”, if applicable).

EXCLUSIONS AND LIMITATIONS

This Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

1. **Acupuncture Services**

   This Plan does not cover acupuncture services, except as described in this EOC in Section “Acupuncture and chiropractic care” or as required by law.

2. **Chiropractic Services**

   This Plan does not cover chiropractic services, except as described in this EOC in Sections “Acupuncture and chiropractic care” and “Services that Do Not Require A Referral” or as required by law.

3. **Clinical Trials**

   This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in section “Clinical Trials” or as required by law.

   Coverage of Approved Clinical Trials does not include the following:

   - The investigational drug, item, or service itself.
   - Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
   - Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
   - Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

   This exclusion does not limit, prohibit, or modify a Member’s rights to the Experimental Services or Investigational Services independent review process as described in this EOC in section “Clinical Trials,” or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in section “Independent Medical Review (IMR).”

4. **Cosmetic Services, Supplies, or Surgeries**

   This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as required by law. This Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as required by law.

   This exclusion does not apply to the following:

   - Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
   - Reconstructive surgery as described in this EOC in section Reconstructive Surgery.
   - For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in section Gender Dysphoria.

5. **Custodial or Domiciliary Care**

   This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law.

   This exclusion does not apply to the following:

   - Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
   - Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
   - Custodial care provided in a healthcare facility.

6. **Dental Services**

   This Plan does not cover dental services or supplies, except as required by law.

7. **Dietary or Nutritional Supplements**

   This Plan does not cover dietary or nutritional supplements, except as required by law.

8. **Disposable Supplies for Home Use**

   This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in Section “Diabetic supplies, equipment, and services” or as required by law.

9. **Experimental Services or Investigational Services**

   This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in section “Independent Medical Review of Experimental/Investigational Treatments” or as required by law.

   Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

   Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

   (1) Testing is not complete; and

   (2) The efficacy and safety of such services in human subjects are not yet established; and

   (3) The service is not in wide usage.

   The determination that a service is an Experimental Service or Investigational Service is based on:

(1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);

(2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;

(3) Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in section "Independent Medical Review (IMR)". In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See section "Independent Medical Review (IMR)."

10. Vision Care

This Plan does not cover vision services, except as described in this EOC in section "Outpatient Services" and as specified in a benefit rider, if purchased, or as required by law.

11. Hearing Aids

This Plan does not cover hearing aids, except as described in a benefit rider or as required by law.

12. Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.

13. Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as required by law.

This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

14. Prescription Drugs / Outpatient Prescription Drugs

This Plan does not cover the following Prescription Drugs, except as described in this EOC in sections "Prescription Medication Benefit," "Home Self-Injectable Medications," and "Family Planning" or as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease. Prescription Medications for treatment of impotence and/or sexual dysfunction are limited to eight (8) pills per thirty (30)-day period, unless Medically Necessary.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
  - Insulin,
  - Over-the-counter drugs as covered under preventive services (e.g., over-the-counter FDA-approved contraceptive drugs),
  - Over-the-counter drugs for reversal of an opioid overdose, or
  - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

15. Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as required by law.

16. **Personal or Comfort Items**

    This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

17. **Reversal of Voluntary Sterilization**

    This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.

18. **Surrogate Pregnancy**

    This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.

19. **Therapies**

    This Plan does not cover the following physical and occupational therapies, except as described in this EOC in sections “Outpatient Services,” “Inpatient Services” and “Mastectomy and Reconstructive Breast Surgery” or as required by law:

    - Massage therapy, unless it is a component of a treatment plan;
    - Training or therapy for the treatment of learning disabilities or behavioral problems;
    - Social skills training or therapy; and
    - Vocational, educational, recreational, art, dance, music, or reading therapy.

20. **Routine Physical Examination**

    The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law

21. **Travel and Lodging**

    This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as required by law.

22. **Weight Control Programs and Exercise Programs**

    This Plan does not cover weight control programs and exercise programs, except as described in this EOC in sections “Nutritional Counseling” and “Appendix A” or as required by law.

BECOMING AND REMAINING A MEMBER OF WHA

Eligibility and Application for Group Coverage

Eligibility requirements and enrollment dates for your participation in WHA’s group health coverage are set in accordance with state and federal law. You and your eligible Family Members apply for membership through your employer group. The date on which you become eligible to enroll is established by your employer and agreed to by WHA. WHA must receive your written application within thirty (30) days of your becoming eligible to enroll.

The eligibility rules shown in this section are WHA’s eligibility rules for you and your dependents. Subscribers and dependents must also meet the employer’s eligibility requirements.

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

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

Subscribers

To be eligible as a Subscriber, you must:

1. Be an employee (as defined by state and federal law) of an employer that has entered into a Group Service Agreement with WHA;

2. Work the minimum number of hours established by WHA and your employer;
3. Meet any applicable waiting periods required by your employer;
4. Enroll during an Open Enrollment Period or a Special Enrollment Period as permitted under state law and regulations;
5. Live or work within the WHA Service Area; and
6. Satisfy any other requirements of your employer.

Service Area Requirement

Except as described below, all Subscribers and their 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 Member no longer lives or works in the WHA Service Area, they are no longer eligible for coverage.

Living and working outside the WHA Service Area is a material fact that must be reported to WHA by the employer, Subscriber or Member. Regardless of when WHA is notified, the Member's eligibility for coverage ends immediately if neither the residence nor work location are within the Service Area. **Note:** WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Eligible Dependents ("Family Members") and Age Limits

Eligible Family Members include:

- Your legal spouse or adult registered domestic partner (see below for details). (The term "spouse" used in this EOC/DF includes your adult registered domestic partner as defined below.)
- Your and your spouse's children under the age of twenty-six (26), including natural children, stepchildren, legally adopted children and children under legal guardianship of the Subscriber and the Subscriber's spouse ("Child[ren]").
- A Child may enroll even if:
  1. The Child was born out of wedlock.
  2. The Child is not claimed as a dependent on the parent's federal income tax return.
  3. The Child does not reside with the parent or is married. **Note:** The Child must live or work within WHA's Service Area, unless coverage for the Child is mandated by a qualified medical support order. Eligibility for children residing outside the Service Area does not relieve the Child from the requirement that all Covered Services must be obtained from WHA's network of Participating Providers, except in an Emergency Care situation or an Urgent Care situation where the Child receives services from an Urgent Care facility outside WHA's Service Area.
  4. The Child does not reside within WHA's Service Area, but only if one of the following apply:
     a. The Subscriber or other eligible dependent parent is subject to a qualified medical support order requiring the parent to provide coverage for the Child; or
     b. The child is a full-time student at an accredited post-secondary institution. Student verification is required. Full-time means the student is taking at least nine (9) semester units (or equivalent hours) at an accredited college, university or vocational school. Breaks in the school calendar do not disqualify the Child from coverage as a full-time student.

For medical leaves of absence from full-time student status, the Child may be eligible for continued coverage under the paragraph entitled "Physically or mentally disabled" later in this section. If the nature of the Child's injury, illness or condition does not make the Child eligible for continued coverage as described in the paragraph entitled "Physically or mentally disabled" the Child's coverage will not terminate for a period not to exceed twelve (12) months or until the date on which the coverage is scheduled to terminate

pursuant to the Group Service Agreement and this EOC/DF, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the Physician determines the illness prevented the Child from attending school, whichever comes first.

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

- Physically or mentally disabled, unmarried dependent children over age twenty-six (26) who are incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition incurred prior to age twenty-six (26), and who are dependent upon you for support. WHA will send you a notice that a covered dependent child will be terminated at least ninety (90) days in advance of the covered dependent child's twenty-sixth (26th) birthday. If the covered dependent child qualifies as set forth in this paragraph, the Subscriber must submit written proof of the disability and certification of the dependent child's dependence upon the Subscriber for support within sixty (60) days of the date you receive the notice. WHA will determine whether the child meets the requirements in this section before the child's twenty-sixth (26th) birthday. If the child does meet the requirements, after two (2) years WHA may request proof each year.

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

Adult Registered Domestic Partners

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

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

Ineligibility

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

Effective Date of Coverage

Your effective date of health coverage is as follows:

- If your employer is new to WHA and you are enrolling in the Plan, coverage begins on the date the group health plan becomes effective.
- If you are newly eligible to enroll, coverage begins on the first day of the month following the

month in which you meet eligibility requirements and enroll in the plan.

- Your or your spouse's newborn Child is temporarily covered for thirty (30) days from the date of birth. If the mother is a WHA member, the newborn Child must obtain services from providers within the mother's Medical Group 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. Your spouse, if not previously enrolled in the Plan, may enroll at the same time as the newborn Child if your spouse meets all eligibility requirements.
- For children adopted after you have enrolled, WHA must receive notification to enroll the Child along with documentation within thirty (30) days of the date adoptive custody starts. Coverage begins on the date adoptive custody starts.
- Coverage for other Family Members who become eligible after you have enrolled (i.e., through marriage) begins on the first of the month following the date of the qualifying event. WHA must receive notification within thirty (30) days of eligibility.

Open Enrollment

Under state law, Open Enrollment is held once a year. Coverage begins on the date established by your employer and agreed to by WHA. If you fail to enroll during an Open Enrollment Period or within thirty (30) days of becoming newly eligible, you must wait until your employer's next Open Enrollment Period.

Special Enrollment

If you fail to enroll during an Open Enrollment Period, you must wait until the next Open Enrollment Period to enroll, unless one of the following applies and you apply for enrollment within thirty (30) days of the applicable event:

1. All of the following:
    a. You were or your eligible dependent was covered under another employer health benefit plan, COBRA continuation coverage, Medicare, Medi-Cal or another government-sponsored program providing health benefits when initially eligible to enroll in this health plan;
    b. You or your eligible dependent certified in writing when first eligible for enrollment in this health plan that coverage under a plan described in a. above was the reason for declining enrollment in this health plan, provided that you were or your eligible dependent was given the opportunity to make such certification and notified that failure to do so could result in WHA's excluding coverage;
    c. You have or your eligible dependent has lost or will lose Minimum Essential Coverage under another employer health benefit plan as a result of termination of employment, change in employment status, termination of the other plan's coverage, the death of or divorce or legal separation from the person through whom you were or your eligible was covered as a dependent, exhaustion of COBRA continuation coverage, loss of Medicare, Medi-Cal or other government-sponsored coverage; and
    d. You request or your eligible dependent requests enrollment in this health plan within thirty (30) days after termination of coverage or cessation of employer contribution toward coverage provided under another employer health benefit plan.

- Exception: Your or your eligible dependent may request enrollment within sixty (60) days after termination of Medicare, Medi-Cal or other government-sponsored coverage.

2. You gain a dependent. Both you and the dependent are eligible to enroll. For more information, see “Effective Date of Coverage” earlier in this section.
3. A court has ordered coverage for your spouse or minor child.
4. WHA cannot produce a signed declination of coverage statement from your employer. Valid declination of coverage statements must include in boldface type that failure to elect coverage at the time of initial eligibility permits WHA to impose an exclusion from coverage for a period of twelve (12) months.
5. You previously declined coverage and subsequently acquired an eligible dependent, and you enroll yourself and your eligible dependent within thirty (30) days following the date that person becomes your dependent.

- The effective date of coverage for late enrollment under this section will be the first day of the first calendar month following the date the completed request for enrollment is received by WHA.

Loss of Eligibility

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

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

Loss of eligibility does not affect your right to continue group coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as described below, unless your loss of eligibility is due to not living or working within the Service Area.

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

Your spouse loses eligibility if:

- You divorce, or you become legally separated.

Your children lose eligibility as dependents if they:

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

Termination Due to Loss of Eligibility

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

Termination for Fraud or Misrepresentation

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

- You seek and/or obtain medications under false pretenses to support a drug dependency or for the illegal sale of medications.
- You obtain or attempt to obtain Covered Services by means of fraud or intentional material misrepresentations, you permit any other person to use a Member’s identification card to obtain services or otherwise employ deception in the use of your identification card, or you engage in any fraudulent conduct.
- You intentionally mislead WHA about whether you live or work in the Service Area.

Rescission

WHA may rescind its contract with you if you commit fraud or intentionally misrepresent a material fact. Rescission means a termination of your membership that is retroactive back to the date of enrollment.

Examples of material facts include, but may not be limited to:

- Information including, but not limited to, residence address, age and gender provided during the enrollment process.
- Information about your eligibility for WHA coverage.
- WHA will not rescind its contract with you after the first twenty-four (24) months of your coverage. Your membership may still be terminated after twenty-four (24) months as explained in this section.

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

Termination for Discontinuance of a Product

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 your employer 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 employer's group coverage can be terminated for any reason set forth in the Group Service Agreement. Also, your employer 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.

Effective Date of Termination of Coverage for Group Members

Coverage as a Member of a group ends as explained below.

- At midnight on the first day of the month following the last month in which you were eligible and for which your employer has made payment to WHA and you have made any required contribution to your employer.
- At midnight on the termination date specified in the section "Termination of Benefits, Fraud and Exception to Cancellation," "Termination." (Consult your employer's Group Service Agreement for further details.)
- On the termination date established by WHA and your employer as specified in your employer's Group Service Agreement, or as otherwise agreed by your employer as long as such termination is permitted by state and federal law.

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

<u>Your Right to Elect Continuation Coverage.</u> 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 Western Health Advantage – or to the employer if the employer administers the plan under contract with Western Health Advantage – not later than sixty (60) days after the date of the Qualifying Event:

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:

Western Health Advantage
Attn: COBRA Enrollment Department
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 WHAWHA 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 Members 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. You will receive a Notice of Start of Grace Period after your last date of paid coverage. If your premium remains unpaid at the end of the grace period, your coverage will terminate and you will receive a Notice of End of Coverage.

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 and Deductibles. 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,
- when the Member is covered under a replacement agreement or policy without limitations as to the disabling condition.

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 and Deductibles.

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.

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. For services that are subject to the Deductible, you pay the Copayment only after the Deductible is met. See the “Liability of Member for Payment” section under the “Introduction” to this EOC/DF for more information. Also see the Copayment Summary for specified Copayments.

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

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

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

Deductibles

In any calendar year, if you have a medical Deductible listed on your Copayment Summary, you must meet a Deductible for Covered Services rendered to you, except for “Preventive Care Services”. A complete list of preventive care services that are not subject to the Deductible is in Appendix

A. Any payments for non-Covered Services do not count toward the Deductible, nor do any payments for benefits purchased separately as a rider.

The Charges you pay for services subject to the Deductible are WHA's Contracted Rates with our Participating Providers and/or Medical Groups. For this reason, it is very important that you show your most current Member ID card to your provider so you are charged the appropriate amount.

If you have both a medical Deductible and a prescription Deductible, the medical Deductible and the prescription Deductible must each be met separately.

Please refer to the Copayment Summary to learn the amount of your Deductible and for information on tracking your payments toward the Deductible each calendar year.

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

Copayments and Deductibles for Newborns

Copayments and Deductibles are incurred by newborn Children, whether or not the newborn Child is enrolled in WHA 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.

Copayments and Deductibles for Covered Services from Certain Non-Participating Providers

To the extent Covered Services are provided by a non-Participating community paramedicine program, triage to alternate destination program, or mobile integrated health program, the cost-sharing amount will be no more than if the same Covered Services were provided by a Participating community paramedicine program, triage to alternate destination program, or mobile integrated health program.

Reimbursement Provisions

If, in an emergency, you have to use non-Participating Hospitals or Physicians, WHA will reimburse you for Charges or will arrange to pay the providers directly, minus applicable Copayments and/or Deductibles. **Whether provided by Participating or Non-Participating Providers, WHA covers your emergency services, including air-ambulance and ground ambulance services; and your only liability is the applicable copayment and/or deductible.** Requests for reimbursement must be submitted within one hundred eighty (180) days of the date services were rendered, with proof of payment enclosed.

If you need to submit a claim sign in at mywha.org and choose the Request Reimbursement option under the MyTOOLS and complete the Claim Reimbursement Form. You can also contact Member Services at 916.563.2250, 888.563.2250 toll-free or 711 TTY to find out where and how to submit it.

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

Non-participating hospitals and Physicians are prohibited under state and federal law from billing you more than your applicable copayment and/or deductible for emergency services. When you receive emergency services from a non-participating hospital or Physician, WHA will receive a bill and will pay the reasonable and customary value for the services, as required by law. Regardless of the amount of the total

billed charges, you are never responsible for more than your applicable copayment and/or deductible for hospital or physician services provided in an emergency. If you were billed more than your applicable copayment and/or deductible for emergency services provided by a non-participating hospital or Physician, you may report the provider to the California Department of Managed Health Care by calling 888.466.2219. You may also contact Member Services at 916.563.2250, 888.563.2250 toll-free or 711 TTY for assistance.

Out-of-Pocket Maximum Liability

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

The Copayments and Deductibles you pay during the calendar year (including medical, pharmacy, acupuncture, and MHSUD) will be applied to the OOP, except as described below. When you pay a Copayment or Deductible for Covered Services, ask for and keep the receipt. When the receipts add up to the amount of the annual OOP, submit your receipts to WHA. Please call our Member Services Department to find out where to submit your receipts. After you submit your receipts showing that you have met the OOP, WHA will provide you with a document that shows you do not have to pay any additional Copayments or Deductibles for Covered Services through the end of the calendar year.

Cost-sharing payments for Prescription Medications that are not on the formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.

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

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

- Chiropractic
- Adult vision and hearing exams
- Any payments for any benefits purchased separately as a rider, except for the prescription rider

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

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

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

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

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

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

Coordination of Benefits

Coordination of benefits ("COB") is a process used by WHA and other health plans, employer benefit plans, union welfare plans, HMOs, insurance companies, government programs and other types of payors to

make sure that duplicate payments are not made for the same claims when more than one Insurer covers a Member. This section summarizes the key rules by which WHA will determine the order of payment of claims while providing that the Member does not receive more than one hundred percent (100%) coverage from all plans combined.

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

Definitions

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

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

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

1. Plan Without COB Provision is Primary Plan

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

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

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

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

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

4. How Primary Plan for Divorced or Legally Separated Spouses is Determined
   a. If spouses are legally separated or divorced and a court decree directs one parent to be financially responsible for the child's medical, dental or other health care expenses, the plan of the parent who is financially responsible will be the Primary Carrier.
   b. If there is no court decree regarding health care responsibility, the plan of the parent with custody is the Primary Plan.
5. Unmarried Spouses With Legal Custody

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

6. Remarried Spouses

In the case of a divorced parent, when the court has not assigned financial responsibility for the child's medical, dental or other health care expenses, and the parent has remarried, the plan who covers the child as the dependent of the parent with custody is the Primary Plan, and the stepparent's plan is the Secondary Plan. The plan of the parent without custody is tertiary. If the parent with custody does not have his or her own health coverage, the stepparent's plan is then the Primary Plan and the plan of the parent without custody becomes the Secondary Plan.

7. When the Court Orders Joint Custody

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

8. Retired and Laid-off Employees

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

providing coverage as a retirement benefit is secondary.

9. When rules one (1) through eight (8) do not establish an order of benefit determination, the Insurer who has covered the patient the longest is the Primary Plan.

Rules for Coordination with Medicare Coverage

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

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

1. Working Aged

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

   a. An age 65 or over working individual who:
      1. Works for an employer that employs 20 or more employees, and
      2. Is covered under that employer's health plan and entitled to Part A & B
   b. Age 65 or over and a spouse of a worker employed by an employer of 20 or more employees who is covered under an employer's health plan and entitled to Part A & B, or
   c. A self-employed worker or spouse age 65+ who is:
      1. Covered by the employer's health plan through association with a firm which employs 20 or more employees, and
      2. Entitled to Part A & B.

2. Retiree

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

3. End Stage Renal Disease/Permanent Kidney Failure

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

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

4. Disability
   a. A WHA commercial plan is primary for Members under the age of 65 who have Medicare because of a disability and who are covered under a Large Group Health Plan (LGHP) through their current employment or through the current employment of any family member. An LGHP is an employer which employs at least 100 employees.

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

Other COB Rules

1. Duplicate Coverage
   a. If a Member is covered by more than one WHA commercial group plan, WHA will use the COB rules under "Rules When There is More Than One Commercial (Non-Medicare) Plan" to determine which plan is primary. Members covered by more than one WHA plan who are not enrolled with the same PCP for both plans will not benefit from lower cost-

sharing that would otherwise occur as a result of being enrolled in multiple plans.

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

2. Pharmacy Benefits

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

3. Disagreements With Other Insurers

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

Third Party Responsibility – Subrogation

If a Member suffers injury, illness or death due to the act or omission of another person (a "third party"), WHA will, with respect to services provided in connection with that injury, pay for and/or provide Covered Services, but will retain the right to seek 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 non-capitated Covered Services pursuant to its reimbursement rights described in this EOC/DF is determined in accordance with California Civil Code Section 3040. This calculation is not applicable to workers' compensation liens, may not apply to certain ERISA plans, hospital liens, and Medicare plans and certain other plans, and may be modified by written agreement. Reimbursement related to worker’s compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by Civil Code Section 3040 will be determined in accordance with the provisions of this EOC/DF and applicable law.

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

Other Limitations on Coverage

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

MEMBER SATISFACTION PROCEDURE

Benefit Questions and Clarifications

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

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

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

Information and Assistance in Other Languages

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

Appeal and Grievance Procedure

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

Western Health Advantage
Attn: Appeals & Grievances Department
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Please include a detailed description of your situation or questions and your reasons for dissatisfaction with any supporting documentation, to WHA Appeals & Grievances 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 WHA Member Services. If you would like assistance in filing a Grievance or an Appeal, please call WHA 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, upon request, 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 you and will include an explanation of the contractual or clinical rationale for the decision. Contact WHA Member Services for more detailed information about the - Appeal and Grievance procedure.

Department of Managed Health Care Information

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-888-563-2250 or 711 TTY)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for

more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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

Grievances Related to Vision Benefits

If you have a complaint or grievance regarding your vision benefits relating to eye exams, or vision prescriptions, or vision materials benefits (such as eyeglasses or contacts), if such services are offered under your plan, call VSP Member Services at 800.877.7195, or you can submit a complaint or grievance to:

VSP Vision Care
Attn: Complaint & Grievance Unit
P.O. Box 997100
Sacramento, CA 95899-7100

Or:

Fill out a form using the below link:
https://www.vsp.com/contact-us/grievance

Grievances Related to Mental Health and Substance Abuse Disorder Benefits

USBHPC administers all levels of review under WHA's Grievance Process for Complaints regarding Mental Health or Substance Use Disorder Services. If you have a complaint or grievance regarding your MHSUD benefits, you should first call USBHPC's Customer Service Department at 800.765.6820 (TDD Line 711), or you may submit a written Grievance to USBHPC. A Grievance form and a description of the Grievance procedures are available at every USBHPC Participating Provider office and USBHPC facility, and on USBHPC's web site. In addition, a Complaint Form will be promptly sent to you if you request one by calling USBHPC's Customer Service Department.

You may submit the Grievance form to:

The USBHPC Web Site:
www.liveandworkwell.com

Or by mail to:

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

Or:

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

Or Fax: 855.312.1470

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 WHA Member Services at the number listed below.

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

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

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

Independent Medical Review (IMR)

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

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

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

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

There is no application or processing fee required.

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

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

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

Independent Medical Review of Experimental/Investigational Treatments

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

beneficial for the treatment of a condition or illness than the available standard treatment.

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

If you have a Life-Threatening or Seriously Debilitating Condition and it is determined by a Physician that you are likely to die within two (2) years or that your health or ability to function could be seriously harmed by waiting the usual thirty (30) business days for review; if your treating Physician certifies that you have 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 you or your 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 a Member participate in the Plan's Grievance system prior to seeking an IMR of a decision to deny coverage on the basis that the treatment or service is considered experimental/investigational.

The written request can be submitted to the Plan at:

Western Health Advantage
Attn: Appeals & Grievances Department
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

You have the right to request an Independent Medical Review when coverage is denied as an Experimental or Investigational Procedure and your Physician certifies that you have a terminal condition for which standard therapies are not or have not been effective in improving your condition, or would not be medically appropriate for you, 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 a Member 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 your application for an IMR, WHA will submit all of your 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 you are not in a Life-Threatening or Seriously Debilitating Condition or if your 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, you and/or the Physician.

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

Notice of Non-Discrimination

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

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

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

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

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

Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
888.563.2250 or 916.563.2250, 711 (TTY)
fax 916.563.2207
appeal.grievance@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 http://www.hhs.gov/ocr/office/file/index.html

Binding Arbitration

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

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

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

If the parties fail to reach an agreement on arbitrator(s) within thirty (30) days of the filing of the arbitration with 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:

Western Health Advantage
Attn: CFO
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 JAMS at jamsadr.com or 916.921.5300.

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

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

DEFINITIONS

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

Abuse/Misuse means the intentional and inappropriate use of a product or medicine in a manner or dose other than intended or prescribed.

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Annual means once every 12 months.

Appeal means a formal request, either verbal or written, by a practitioner or Member for second level reconsideration of a health plan or medical group decision, such as a Utilization Review recommendation, a benefit payment, or an administrative action.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health.
  - The federal Centers for Disease Control and Prevention.
  - The Agency for Healthcare Research and Quality.
  - The federal Centers for Medicare and Medicaid Services.
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The United States Department of Veterans Affairs.
    - The United States Department of Defense.
    - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

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

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

CALOCUS-CASSII means the Child and Adolescent Level of Care/Service Intensity Utilization System assessment tool released by the American Association for Community Psychiatry that assists in making decisions about treatment and support services for behavioral health conditions in ages 6 to 18.

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 is the same as "Grievance".

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 Member's Copayment Summary. Percentage Copayments are based on WHA's contracted rates for service.

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

Coverage Decision means the approval or denial of health care service by the Plan or by one of its Contracted Medical Groups, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Plan contract. This includes medical necessity review of proposed services or treatments that are experimental and/or investigational in nature. This does not encompass a decision regarding a Disputed Health Care Service.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

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

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

Dental Services means any services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar bone, 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.

Doula means a non-medical birth worker who provides health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth including support during miscarriage, stillbirth and abortion.

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

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

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

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

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 Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

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 as described in this EOC in section Eligible Dependents ("Family Members" and Age Limits.

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

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

Grievance means any written or oral expression of dissatisfaction regarding WHA and/or a provider, including quality of care concerns, and shall include any complaint, dispute, request for reconsideration or appeal made by a Member, or the Member's representative.

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

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

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 a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide supportive care to the primary caregiver and the family of the hospice patient, and that meets all of the following criteria:

- Considers the patient and the patient's family, in addition to the patient, as the unit of care.
- Utilizes an interdisciplinary team to assess the physical, medical, psychological, social, and spiritual needs of the patient and the patient's family.
- Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care that emphasizes supportive services, including, but not limited to, home care, pain control, and limited inpatient services. Limited inpatient services are intended to ensure both continuity of care and appropriateness of services for those patients who cannot be managed at home because of acute complications or the

temporary absence of a capable primary caregiver.

- Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.
- Provides for bereavement services following death to assist the family in coping with social and emotional needs associated with the death of the patient.
- Actively utilizes volunteers in the delivery of hospice services.
- To the extent appropriate, based on the medical needs of the patient, provides services in the patient's home or primary place of residence.

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

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to 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. Your Plan must pay for the services if an IMR decides you need it.

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

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage.

Life-Threatening means either or both of the following:

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

LOCUS means the Level of Care Utilization System assessment tool released by the American Association for Community Psychiatry that assists in making decisions about treatment and support services for behavioral health conditions.

Maintenance medication is commonly used in the treatment of chronic conditions (like arthritis), and are usually administered continuously rather than intermittently.

Medical Director means a Physician employed by or under contract with WHA, having the responsibility for implementing WHA's Utilization Review 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 a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted

standards of Mental Health or Substance Use Disorder care.

- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

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, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Mental Health or Substance Use Disorder 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.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

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 Retail Pharmacy is a pharmacy under contract with Optum Rx, authorized to dispense covered Prescription Medications to members who are entitled under the pharmacy benefit to receive them. Optum Rx allows a Member to fill their prescription at any of its Participating Pharmacies nationwide. Refer to the WHA Provider Directory for a list of Participating Pharmacies.

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

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

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

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

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

the document on WHA's website at westernhealth.com.

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

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

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

Prescription Drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "prescription drug'' includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.

Primary Care Physician or PCP means a Participating Physician who:

- Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology;
- 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
- Is designated as a Primary Care Physician by the Medical Group.

Primary Residence applies to each Member individually, and means a residence in which the Member 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 Member resides only on a limited basis (such as only on weekends) does not qualify as a Primary Residence.**

Primary Workplace applies to each Member individually, and means a location where the individual performs at least half of the work that the individual performs for the employer providing this WHA group health plan.

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

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

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

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute

symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Residential Treatment Center means a residential facility that provides services in connection with the diagnosis and treatment of Mental Health and Substance Use Disorders, including:

- Intensive short-term residential services, as described in the most recent versions of LOCUS and CALOCUS-CASSII.
- Moderate intensity intermediate stay residential treatment programs, as described in the most recent versions of LOCUS and CALOCUS-CASSII.
- Moderate Intensity long-term residential treatment programs, as described in the most recent versions of LOCUS and CALOCUS-CASSII.
- High intensity acute medically managed residential programs, as described in the most recent versions of LOCUS and CALOCUS-CASSII.
- Medically managed extended care residential programs, as described in the most recent versions of LOCUS and CALOCUS-CASII.
- ASAM residential levels of care, as described in the most recent version of *The ASAM Criteria.*

Sensitive Services means health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, obtained by a Member at or above the minimum age specified for consenting to the service.

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

Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

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

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

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

Tier 1

- Most generic drugs and low cost preferred brands.

Tier 2

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

Tier 3

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

Tier 4

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

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

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

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.

Utilization Review means the process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UR process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

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

WHA means Western Health Advantage.

APPENDIX A*
Preventive Services Covered Without Cost-Sharing

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

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

Service	Men	Women	Pregnant Women	Children
Falls in Older Adults, Counseling, Preventive Medication and Other Interventions[22]	x	x		
Folic Acid Supplementation to Prevent Neural Tube Defects, Preventive Medication (Generic Required, Brand Name is Not Covered)[23]		x	x	
Gestational Diabetes Mellitus, Screening[24]			x	
Gonorrhea, Ocular Prophylactic Medication[25]				x
Gonorrhea, Screening[26]		x	x	
Group B Streptococcus, Screening			x	
Hearing Loss in Newborns, Screening[27]				x
Hemoglobin/Hematocrit in Childhood[28]				x
Hepatitis B Virus Infection in Pregnant Women, Screening[29]			x	
Hepatitis B Virus Infection, Screening – Adolescent, Adult[30]	x	x		x
Hepatitis C Virus Infection, Screening[31]	x	x		x
High Blood Pressure in Adults 18+, Screening	x	x	x	
HIV, Screening[32]	x	x	x	x
HPV, Screening[33]		x		
HPV, Vaccination[34]	x	x		x
Immunizations[35]	x	x		x
Intimate partner violence screening: women of reproductive age[36]		x		
Iron Deficiency – Anemia, Prevention – Counseling by PCP[37]			x	x
Latent TB Infection, Screening[38]	x	x	x	
Lead, Screening for at-risk children				x
Lipid Disorders in Adults, Screening	x	x		
Lung Cancer, Screening[39]	x	x		
Major Depressive Disorder in Children and Adolescents, Screening[40]				x
Obesity in Adults, Screening[41]	x	x		
Obesity in Children and Adolescents, Screening[42]				x
Osteoporosis, Screening[43]		x		
Phenylketonuria (PKU), Screening[44]				x
Perinatal Depression: Preventive Interventions		x	x	
Postpartum Care[45]		x		
Prediabetes and Type 2 Diabetes: Screening[46]	x	x	x	
Preeclampsia, Prevention: Low-dose Aspirin[47]			x	

Service	Men	Women	Pregnant Women	Children
Preeclampsia, Screening			x	
Prenatal Screening Under the California Prenatal Screening Program[48]			x	x
Prevention of HIV Infection: Preexposure Prophylaxis[49]	x	x	x	x
Prostate Cancer, Screening[50]	x			
Rh (D) Incompatibility, Screening[51]			x	
Sexually Transmitted Infections, Counseling[52]	x	x		x
Sickle Cell Disease in Newborns, Screening[53]				x
Skin Cancer Prevention, Counseling[54]	x	x		x
Statins for the Primary Prevention of Cardiovascular Disease[55]	x	x		
Sterilization Procedures[56]	x	x		
Syphilis Infection, Screening[57]	x	x	x	
Tobacco Use in Adults, Counseling and Interventions (Brand Name Medications Not Covered)[58]	x	x	x	
Tobacco Use in Children and Adolescents, Primary Care Interventions[59]				x
Visual Impairment in Children Ages 1 to 5 Years, Screening[60]				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/uspstf/recommendation-topics/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.

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

[2] Once per pregnancy for pregnant individuals between 15 and 20 weeks' gestation.

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

[6] For children and adolescents aged 8 to 18 years.

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

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

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

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

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

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

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

[14] Lactation support, supplies and counseling during pregnancy and post-partum to promote and support breastfeeding. Includes rental/purchase of a non-hospital grade breast pump.

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

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

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

[18] Newborns.

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

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

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

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

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

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

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

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

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

[28] Perform risk assessment or screening, as appropriate, per recommendations in current edition of AAP (at 4 month and 12 months up to 19 years).

[29] Pregnant women at first prenatal visit.

[30] Adolescents and adults at increased risk.

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

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

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

[34] The HPV vaccine is covered for members for whom the vaccine is approved by the FDA.

[35] 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).

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

[37] 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.

[38] Asymptomatic adults at increased risk for infection, including asymptomatic pregnant women.

[39] 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.

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

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

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

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

[44] Newborns.

[45] One comprehensive postpartum visit is covered as preventive care following a vaginal delivery. For women that deliver via Cesarean section, two visits will be covered as preventive care to allow for a post-surgical follow-up and a comprehensive postpartum visit. The comprehensive postpartum visit should occur no later than 12 weeks after birth.

[46] 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.)

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

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

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

[50] Recommended screening age: Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years. Age 45 for men at high risk of developing prostate cancer. This includes African American men and men who have a first-degree relative (father or brother) diagnosed with prostate cancer at an early age (younger than age 65). Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).

[51] 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.

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

[53] Newborns.

[54] 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.

[55] 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.

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

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

[58] 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.

[59] 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.

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

Infertility, Fertility, and Family-Building Services

When offered under your plan, infertility and fertility diagnosis and treatment services and prescribed medications are covered when authorized in advance by WHA and determined to be medically appropriate by a Participating Provider.

WHA defines “infertility” as a condition or status characterized by any of the following:

- A licensed physician’s findings, based on the patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- A person’s inability to reproduce either as an individual or with their partner without medical intervention.
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. “Regular, unprotected sexual intercourse” means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Covered Services

Applicable Copayments for the following services and prescribed medications are consistent with other health benefits and contribute to the annual deductible and out-of-pocket maximum.

- **Office visits** for consultation, diagnosis or treatment of infertility or fertility with a Participating Provider.
- **Basic laboratory and imaging tests** for diagnosis or evaluation of infertility or fertility. This may include, but are not limited to, services such as: progesterone testing, thyroid function, prolactin levels, follicle-stimulating hormone (FSH), estradiol, anti-mullerian hormone (AMH), vaginal ultrasounds, hysterosalpingogram (HSG), hysteroscopy, testosterone test, sperm analysis, scrotal ultrasound.
- **Genetic testing** that is medically necessary for the prenatal diagnosis of a rare and severe genetic condition when a Member meets one or more of the following criteria:
  - A personal or first degree relative with a WHA-listed genetic condition
  - A fetus from a Member’s prior pregnancy was determined to have one of the WHA-listed genetic condition
  - Both partners are carriers of a WHA-listed genetic condition
  - One partner is a carrier of a WHA-listed genetic condition that is a dominant trait condition

  Note: A Member is found to be a carrier through preconception screening. If the partner is a WHA member, the partner may be covered for carrier testing.
- **Outpatient procedures** for fertility-related service, whether in an office setting or outpatient facility, can include any of the following:
  - Laparoscopy
  - Uterine Lavage
  - Oocyte retrieval (Egg/Ovum) is limited to a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using sign embryo transfer when recommended and medically appropriate, per lifetime. “Lifetime” refers to any attempts, treatments or services rendered during the Member’s coverage under a Western Health Advantage plan at any time during the Member’s lifetime.

- Storage of eggs or embryos
- Sperm collection and storage
- Artificial Insemination (AI)
  - Intravaginal insemination (IVI)
  - Intracervical insemination (ICI)
  - Intrauterine insemination (IUI)
- Assisted Reproductive Technology (ART), which include procedures involving the transfer and/or implantation of egg/ovum/embryo including:
  - In Vitro Fertilization (IVF)
  - Zygote Intra-Fallopian Transfer (ZIFT)
  - Gamete Intrafallopian Transfer (GIFT)
  - Frozen Embryo Transfers (FET)
  - Intracytoplasmic Sperm Injection (ICSI)
- Maternity services, including prenatal, delivery, and postnatal care, are covered for surrogates who are enrolled members of WHA. Maternity services for surrogates who are not WHA members are not covered.

The following services are not included under this benefit:

- Services and supplies to reverse voluntary, surgically induced infertility.
- Treatment of infertility as a result of previous/prevailing elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts.
- Gender-affirming surgeries and hormone therapies.
- Third-party reproduction, such as those involving surrogates, who are not members of WHA.
- Legal fees, agency fees or gestational carrier expenses.
- Ova sticks for the purposes of infertility testing.
- Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of infertility.
- Inoculation of a woman with partner's white cells.

Prescription Drugs

Oral or self-administered medications for the diagnosis or treatment of infertility or fertility are covered and subject to cost shares according to the Preferred Drug List (PDL) and as described under the section entitled "Prescription Medication Benefit." Cost shares for office-administered medications are based on the office or facility where administered.

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PUBLISHED JANUARY 2026