Western Health Advantage: Western 4500/50/40% HMO Prime with Rx Classic

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-563-2250 or visit mywha.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$4,500/Individual or $9,000/Family; Medical services per calendar year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, including preventive care, and other services indicated in the chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,500/Individual or $13,000/Family per calendar year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Member cost shares for annual hearing exams, chiropractic care and premiums and health care the plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See mywha.org/directory or call 1-888-563-2250 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50/visit	Not covered	None
	Specialist visit	$50/visit	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after medical deductible	Not covered	For diagnostic tests, preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services For imaging, preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Imaging (CT/PET scans, MRIs)	No charge after medical deductible	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at mywha.org/pharmacy	Tier 1 (Preferred generic and certain preferred brand name medications)	Retail: $10/prescription; Home Delivery: $20/prescription	Not covered	At Retail, 30-day supply is allowed, or up to 90-day supply for maintenance medications; retail copayment applies per 30-day supply. Home Delivery allows up to 100-day supply. Specialty medications limited to 30-day supply and must be obtained through CVS Caremark Specialty Pharmacy as described in the EOC/DF. Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services. Insulin will not exceed $35 per prescription for a 30-day supply.
	Tier 2 (Preferred brand name or non-preferred generic medications)	Retail: $30/prescription; Home Delivery: $60/prescription	Not covered	
	Tier 3 (Non-preferred medications)	Retail: $50/prescription; Home Delivery: $100/prescription	Not covered	
	Tier 4 (Specialty medications specialty drugs and other higher-cost drugs)	$100/prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after medical deductible	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Physician/surgeon fees	40% coinsurance after medical deductible	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
If you need immediate medical attention	Emergency room care	40% coinsurance after medical deductible	40% coinsurance after medical deductible	Member cost shares for emergency room care are waived if admitted. At urgent care centers, services from an out-of-network provider are covered only when obtained outside the service area.Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
	Emergency medical transportation	40% coinsurance after medical deductible	40% coinsurance after medical deductible	
	Urgent Care Center	$50/visit	$50/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after medical deductible	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
	Physician/surgeon fees	40% coinsurance after medical deductible	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50/visit (professional); No charge (other outpatient services)	Not covered	Preauthorization required for outpatient mental health and residential treatment center. Preauthorization may be required for inpatient mental health. Failure to obtain preauthorization may result in non-payment of services.
	Inpatient services	40% coinsurance after medical deductible	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services, including routine prenatal care and first postnatal visit. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services, a copayment, coinsurance or deductible may apply.Preauthorization may be required for inpatient services. Failure to obtain preauthorization may result in non-payment of services
	Childbirth/delivery professional services	40% coinsurance after medical deductible	Not covered	
	Childbirth/delivery facility services	40% coinsurance after medical deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance after medical deductible	Not covered	100 visits per calendar year. Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Rehabilitation services	$50/visit	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Habilitation services	$50/visit	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Skilled nursing care	40% coinsurance after medical deductible	Not covered	100 days per calendar year. Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Durable medical equipment	40% coinsurance after medical deductible	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
	Hospice services	40% coinsurance after medical deductible	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
If your child needs dental or eye care	Children's eye exam	No Charge (facility); (professional)	Not covered	One comprehensive eye exam per year (including dilation if medically indicated).
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care Adult
- Hearing Aids (unless purchased as a rider)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs (unless purchased as a rider)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion Services
- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care Adult

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Seguro Médico Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help you if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. Additionally, a consumer assistance program can help you file your appeal. For more information about your rights, this notice, or assistance, contact the California Department of Managed Health Care at 1-888-446-2219 or 1-888-877-5378 (TTY) or visit their website www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standard, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

See addendum for notification of nondiscrimination and language assistance.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The Plan's overall Deductible	$4,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	40%
Other Copayment	$50

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth//Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$4,500
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$6,130**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The Plan's overall Deductible	$4,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	40%
Other Copayment	$50

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The Plan's overall Deductible	$4,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	40%
Other Copayment	$50

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

*Note: This plan has other deductibles for specific services included in this coverage example. See 'Are there other deductibles for specific services?' row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

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

Western Health Advantage provides the following services at no cost and in a timely manner:

Reasonable modifications, aids and services to communicate effectively give people with disabilities equal access and opportunities, such as:

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

Language services to ensure meaningful access to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please contact Member Services at 888.563.2250

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 with:

Western Health Advantage, **Section 1557 Coordinator**
2349 Gateway Oaks Drive, Suite 100,
Sacramento, CA 95833,
Phone: 1-888-563-2250 or 1-916-563-2250, 711(TTY)
Fax: 1-916-568-0126
Email: Compliance@westernhealth.com
Online: https://advantage.westernhealth.com/legal/grievance-submission

You can file a discrimination grievance in person or by mail, fax, email, or online. If you need help filing a grievance, our **Section 1557 Coordinator** is available to help you.

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: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services,

200 Independence Avenue, SW, Room 509F, HHH Building,
Washington, D.C. 20201;
Phone: 1-800-368-1019 or 1-800-537-7697 (TDD).

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

This notice is available at Western Health Advantage's website: https://advantage.westernhealth.com/legal/non-discrimination

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get timely 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 សម្រាប់អ្នកត្រចៀកថ្លង់ 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