Western Health Advantage: Advantage 0/15/250 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	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?	$2,500/Individual or $5,000/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.

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	$15/visit	Not covered	None
	Specialist visit	$30/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	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	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 Optum Specialty Pharmacy as described in the EOC/DF. Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
	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)	$100/visit	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Physician/surgeon fees	No charge	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
If you need immediate medical attention	Emergency room care	$100/visit (facility); No charge (professional)	$100/visit (facility); No charge (professional)	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	No charge	No charge	
	Urgent Care Center	$50/visit	$50/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/day, days 1-3	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
	Physician/surgeon fees	No charge	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	$15/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	$250/day, days 1-3 (facility) ; $125/day, days 1-3 (residential treatment center) ; No charge (professional)	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 or coinsurance may apply.Preauthorization may be required for inpatient services. Failure to obtain preauthorization may result in non-payment of services
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250/day, days 1-3	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visits per calendar year. Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Rehabilitation services	$30/visit	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Habilitation services	$30/visit	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Skilled nursing care	$250/day, days 1-3	Not covered	100 days per calendar year. Preauthorization required. Failure to obtain preauthorization may result in non-payment of services
	Durable medical equipment	20% coinsurance	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services
	Hospice services	No charge	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	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	• Long-Term Care	• Routine Foot Care
• Dental Care Adult	• Non-emergency care when traveling outside the U.S.	• Weight Loss Programs (unless purchased as a rider)
• Hearing Aids (unless purchased as a rider)	• Private-Duty Nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion Services	• Bariatric Surgery	• Infertility Treatment
• Acupuncture	• Chiropractic Care	• 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 Health Insurance 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.

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	$0
Specialist Copayment	$30
Hospital (facility) Daily Copayment	$250
Other Copayment	$15

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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$520**

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

The Plan's overall Deductible	$0
Specialist Copayment	$30
Hospital (facility) Daily Copayment	$250
Other Copayment	$15

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	$0
Copayments	$1,200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,210**

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

The Plan's overall Deductible	$0
Specialist Copayment	$30
Hospital (facility) Daily Copayment	$250
Other Copayment	$15

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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