Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage For:** Self + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.westernhealth.com or by calling 1-888-563-2250.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$0**	See the chart starting on page **2** for your costs for services this plan covers. There is a separate medical and pharmacy **deductible**, which are not integrated.
Are there other **deductibles** for specific services?	Yes, **$2,000** Individual/**$4,000** Family for hospitalization, ambulance and skilled nursing facility. **$250** Individual/**$500** Family for Tier **2**, **3** and **4** Medications	You must pay all of the costs for these services up to the specific **deductible** amount before the plan begins to pay for these services.
Is there an **out-of-pocket limit** on my expenses?	Yes, **$6,800** Individual/**$13,600** Family, per calendar year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, **copayments** for optional riders (if applicable), and health care the plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page **2** describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of **providers**?	Yes, for a list of participating **providers**, see **www.westernhealth.com or call 1-888-563-2250**	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page **2** for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	Yes, written approval is required	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page **5**. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45/visit	Not covered	None
	Specialist visit	$75/visit	Not covered	None
	Other practitioner office visit	$45/visit	Not covered	Includes therapy visits, other office visits not provided by either primary care or specialty physician or not specified in another benefit category.
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$40/visit for lab test, $70/visit for x-ray and diagnostic imaging	Not covered	None
	Imaging (CT/PET scans, MRIs)	$300/visit	Not covered	None

If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.westernhealth.com	Tier 1	Retail: $15/script (30 day supply); Mail Order: $37.50/script (90 day supply)	Not covered	None
	Tier 2	Retail: $55/script, after prescription deductible (30 day supply); Mail Order: $137.50/script, after prescription deductible (90 day supply)	Not covered	None
	Tier 3	Retail: $85/script, after prescription deductible (30 day supply); Mail Order: $212.50/script, after prescription deductible (90 day supply)	Not covered	None
	Tier 4	20% up to $250/script, after prescription deductible	Not covered	Specialty Medications may only be obtained through Mail Order or at a UC Davis Health System or Dignity Health System Pharmacy (30 day supply)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% (Facility); 20% (Professional)	Not covered	None
If you need immediate medical attention	Emergency room services	$350/visit (Facility); No charge (Professional)	$350/visit (Facility); No charge (Professional)	Waived if admitted
	Emergency medical transportation	$250/trip, after deductible	$250/trip, after deductible	None
	Urgent care center	$45/visit	$45/visit	Services from non-participating providers are covered only when obtained outside the service area.

If you have a hospital stay	Facility fee (e.g., hospital room)	20%, after deductible (Facility); 20%, after deductible (Professional)	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance abuse inpatient services	20%, after deductible (Facility); 20%, after deductible (Professional)	Not covered	None
	Mental/behavioral health and substance abuse outpatient services	$45/visit (Professional); No charge (other outpatient services)	Not covered	None
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Routine prenatal care and lab tests, and first post-natal visit.
	Delivery and all inpatient services	20%, after deductible (Facility); 20%, after deductible (Professional)	Not covered	None
If you need help recovering or have other special health needs	Home health care	$45/visit	Not covered	100 visits per calendar year
	Rehabilitation services	$45/visit	Not covered	None
	Habilitation services	$45/visit	Not covered	None
	Skilled nursing care	20%, after deductible	Not covered	100 days per benefit period
	Durable medical equipment	20%	Not covered	None
	Hospice service	No charge	Not covered	None
If your child needs dental or eye care	Eye exam	No charge	Not covered	None
	Glasses	No charge	Not covered	Glasses or contact lens benefit limited to once per calendar year.
	Dental check-up	No charge	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Cosmetic surgery
- Hearing aids
- Infertility treatment (unless purchased as a rider)
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Dental care for adults
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Routine eye care for adults
- Routine hearing exams

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in durations and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-563-2250. You may also contact your Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the California Department of Managed Health Care at 1-888-HMO-2219 or 1-888-877-5378 (TTY) or visit their website http://www.hmohelp.ca.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-563-2250.

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

Coverage Examples **Coverage For:** Self + Family | **Plan Type:** HMO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator. Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,785
- **Patient pays** $2,755

Sample care cost:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$105
Co-insurance	$500
Limits or exclusions	$150
Total	**$2,755**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,994
- **Patient pays** $1,406

Sample care cost:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$1,115
Co-insurance	$252
Limits or exclusions	$39
Total	**$1,406**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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