

## Summary of Benefits and Coverage: What this Plan Covers &amp; What You Pay For Covered Services

Western Health Advantage: WHA Silver 70 HDHP HMO 2000/20%  
+ Child Dental

Coverage for: Self + Family | Plan Type: HMO

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 <a href="#">deductible</a> ?	\$2,600/Individual or \$4,000/Family per calendar year (\$2,000 per calendar year if enrolled as single-only)	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, including <a href="#">preventive care</a> , glasses and preventive dental services for children, and annual hearing and adult vision exams	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="#">www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,550/Individual or \$13,100/Family per calendar year	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> and health care the plan doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">mywha.org/directory</a> or call 1-888-563-2250 for a list of network providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required for <a href="#">diagnostic tests</a> . <a href="#">Preauthorization</a> required for imaging.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">mywha.org/pharmacy</a>	Tier 1 (Preferred generic and certain preferred brand name medications)	Retail: 20% <a href="#">coinsurance</a> up to \$250/prescription; Mail order: 20% <a href="#">coinsurance</a> up to \$625/prescription	Not covered	<a href="#">Preauthorization</a> required for specialty medications. At Retail pharmacies, a 30-day supply is allowed; up to a 90-day supply is allowed through Mail Order. Specialty medications may be obtained only through mail order or at a UC Davis Health System or Dignity Health System Pharmacy (30-day supply).
	Tier 2 (Preferred brand name or non-preferred generic medications)	Retail: 20% <a href="#">coinsurance</a> up to \$250/prescription; Mail order: 20% <a href="#">coinsurance</a> up to \$625/prescription	Not covered	
	Tier 3 (Non-preferred medications)	Retail: 20% <a href="#">coinsurance</a> up to \$250/prescription; Mail order: 20% <a href="#">coinsurance</a> up to \$625/prescription	Not covered	
	Tier 4 (Specialty medications)	20% <a href="#">coinsurance</a> up to \$250/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> required.

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 need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> (facility); No charge (professional)	20% <a href="#">coinsurance</a> (facility); No charge (professional)	Member cost shares for <a href="#">emergency room care</a> are waived if admitted. At <a href="#">urgent care</a> centers, services from an <a href="#">out-of-network provider</a> are covered only when obtained outside the service area. <a href="#">Preauthorization</a> may be required.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent Care Center</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> (professional); No charge (other outpatient services)	Not covered	<a href="#">Preauthorization</a> required for outpatient mental health and residential treatment center. <a href="#">Preauthorization</a> may be required for inpatient mental health.
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , including routine prenatal care and first postnatal visit. <a href="#">Preauthorization</a> may be required for inpatient services.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	100 visits per calendar year. <a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	100 days per benefit period. <a href="#">Preauthorization</a> required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required.
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Preauthorization</a> required.

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 your child needs dental or eye care	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered	One comprehensive eye exam per year (including dilation if medically indicated).
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	Not covered	Glasses or contact lens benefit limited to once per calendar year.
	Children's dental check-up	No charge; <a href="#">deductible</a> does not apply	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Cosmetic Surgery</li> <li>• Dental Care Adult</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long-Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-Duty Nursing</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care Adult</li> </ul>

**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.hmohelp.ca.gov](http://www.hmohelp.ca.gov), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the California Department of Managed Health Care at 1-888-HMO-2219 or 1-888-877-5378 (TTY) or visit their website [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov).

**Does this plan provide Minimum Essential Coverage?** Yes

If you don't have [Minimum essential coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 credits](#) 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>	\$2,600	■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>	\$2,600	■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>	\$2,600
■ <a href="#">Specialist Coinsurance</a>	20%	■ <a href="#">Specialist Coinsurance</a>	20%	■ <a href="#">Specialist Coinsurance</a>	20%
■ Hospital (facility) <a href="#">Coinsurance</a>	20%	■ Hospital (facility) <a href="#">Coinsurance</a>	20%	■ Hospital (facility) <a href="#">Coinsurance</a>	20%
■ Other <a href="#">Coinsurance</a>	20%	■ Other <a href="#">Coinsurance</a>	20%	■ Other <a href="#">Coinsurance</a>	20%
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)		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)		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	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$2,600	Deductibles	\$2,600	Deductibles	\$1,900
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$1,329	Coinsurance	\$917	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$34	Limits or exclusions	\$0
The total Peg would pay is	\$3,989	The total Joe would pay is	\$3,551	The total Mia would pay is	\$1,900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Western Health Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

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, age, disability, or sex, you can file a grievance with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Member Services Manager 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>

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>.

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## 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 888.877.5378.

## SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

## CHINESE

如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 888.877.5378。

## VIETNAMESE

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

## TAGALOG

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

**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 888.877.5378로 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 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

**PERSIAN-FARSI**

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث اَدوانتيج) 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 شماره 888.877.5378 پیام تاییپی 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 888.877.5378.

**JAPANESE**

ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250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、888.877.5378までお電話ください。

**ARABIC**

إن كان لديك أو لدى شخص تساعدُه أسئلة بخصوص Western Health Advantage، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو ب رقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

**PUNJABI**

ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਚਿੰਜਸ ਿਕਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁੱਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

**CAMBODIAN-MON-KHMER**

!បសវិស័ប(ប៊ីអិ)ក ឬស្រី \_ /០កំរំខែលកំពុងដួយអ)ក /សសំណង=អំពើ Western Health Advantage 109, អ"ក\$សសវិស"វិទទួលដំនួយនីដព័ក ០០៩ 10\*\*ក\$%ង \* <បសំអ\$ក 10\*\*យមវិសអសំ\*+កំ។ 10ដវិមវ័វិស ្រ \*យ, មួយអ/កបក័០១ប សូមទូរស័ព( "ក\$ក10ច័ក្កក្ក\*នំ !២10លខ 888.877.5378។ 888.563.2250 ឬ TTY ស"#បង

**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 888.877.5378.

**HINDI**

य"द आप, या िजस (कसी क) आप मदद कर रहे हों, कौ Western Health Advantage कौ बारे म' ( )न ह, तौ, आपको अपनी भाषा म, मदद तथा जानकार 3ा4त करने का अ"धकार है। ा-शए कौ साथ बात करने कौ -लए, 888.563.2250 पर या पस्ू & तरह )वण म- असमथ1 ट(ट(व(ई कौ लए 888.877.5378 पर कॉल करौ। दक्षु



**THAI**

หากคุณ หรือคนที่) คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้  
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