

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.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, \$1,500 Individual/ \$3,000 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 annual hearing and adult eye examinations, chiropractic and infertility services, 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	
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	\$40/visit	Not covered	None
	Specialist visit	\$40/visit	Not covered	None
	Other practitioner office visit	\$40/visit	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None

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<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at www.westernhealth.com</p>	Generic drugs	Retail: \$10/prescription (30 day supply); Mail Order: \$20/prescription (90 day supply)	Not covered	None
	Preferred brand drugs	Retail: \$20/prescription (30 day supply); Mail Order: \$40/prescription (90 day supply)	Not covered	None
	Non-preferred brand drugs	Retail: \$50/prescription (30 day supply); Mail Order: \$100/prescription (90 day supply)	Not covered	None
	Specialty drugs	No charge	Not covered	None
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
<p>If you need immediate medical attention</p>	Emergency room services	\$50/visit	\$50/visit	Waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$50/visit	\$50/visit	Services from non-participating providers are covered only when obtained outside the service area.
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fee	No charge	Not covered	None

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If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	No charge	Not covered	None
	Mental/behavioral health inpatient services	No charge	Not covered	None
	Substance use disorder outpatient services	No charge	Not covered	None
	Substance use disorder inpatient services	No charge	Not covered	None
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visits per calendar year
	Rehabilitation services	\$40/visit	Not covered	None
	Habilitation services	\$40/visit	Not covered	None
	Skilled nursing care	No charge	Not covered	100 days per calendar year
	Durable medical equipment	No charge	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	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

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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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Infertility treatment (unless purchased as a rider) • Private-duty nursing 	<ul style="list-style-type: none"> • Dental care for adults (unless purchased as a rider) • Long-term care • Routine foot care 	<ul style="list-style-type: none"> • Hearing aids • Non-emergency care when traveling outside the US • Weight loss programs (unless purchased as a rider)

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.)		
<ul style="list-style-type: none"> • Bariatric surgery • Routine eye care for adults 	<ul style="list-style-type: none"> • Acupuncture • Routine hearing exams 	<ul style="list-style-type: none"> • Chiropractic care

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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.

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Coverage Examples

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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 \$7,540
- Patient pays \$0

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:

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

- Amount owed to providers: \$5,400
- Plan pays \$5,400
- Patient pays \$0

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:

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Coverage Examples

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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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CITY OF SACRAMENTO

\$40 COPAY

COPAYMENT SUMMARY a uniform health plan benefit and coverage matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE/DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

cost to member DEDUCTIBLE

none Deductible amount

ANNUAL OUT-OF-POCKET MAXIMUM

The maximum out-of-pocket expense for a Member per calendar year is limited to either the Individual amount or Family amount, whichever is met first:

\$1,500 Self-only coverage
 \$1,500 Individual with Family coverage
 \$3,000 Family coverage
 none Lifetime maximum

Preventive Care Services

none Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF

- Annual physical examinations and well baby care
- Immunizations, adult and pediatric
- Women’s preventive services
- Routine prenatal care and lab tests, and first post-natal visit
- Breast, cervical, prostate, colorectal and other generally accepted cancer screenings

Note: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered “preventive,” the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in this copayment summary.

Professional Services

\$40 per visit Office visits, primary care physician (PCP)
 \$40 per visit Office visits, specialist
 none Vision and hearing examinations
 \$40 per visit Family planning services

Outpatient Services

Outpatient surgery
 \$40 per visit • Performed in office setting
 none • Performed in facility — facility fees
 none • Performed in facility — professional services
 none Dialysis, infusion therapy and radiation therapy
 none Laboratory tests, X-ray and diagnostic imaging
 none Imaging (CT/PET scans and MRIs)
 none Therapeutic injections, including allergy shots

Hospitalization Services

none Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:
 • Newborn delivery (private room when determined medically necessary by a participating provider)
 • Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy, blood transfusion services, rehabilitative services, and nursery care for newborn babies
 none Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services

cost to member Urgent and Emergency Services

Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:

- \$40 per visit • Physician's office
- \$50 per visit • Urgent care center
- \$50 per visit • Emergency room — facility fees (waived if admitted)
- none • Emergency room — professional services
- none • Ambulance service as medically necessary or in a life-threatening emergency (including 911)

Prescription Coverage

Outpatient prescription medications are excluded on the medical plan and covered under the prescription rider plan (see your Prescription Copayment Summary).

Durable Medical Equipment (DME)

- none Durable medical equipment (excluding orthotic and prosthetic devices) when determined by a participating physician to be medically necessary and when authorized in advance by WHA
- none Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA

Behavioral Health Services

Mental Health Disorders and Substance Abuse

- none • Office visit
- none • Outpatient services
- none • Inpatient hospital services, including detoxification — provided at a participating acute care facility
- none • Inpatient hospital services — provided at residential treatment center
- none • Inpatient physician services

Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).

Other Health Services

- none Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
- none Skilled nursing facility, semi-private room and board, when medically necessary and arranged by a primary care physician, including drugs and prescribed ancillary services, up to 100 days per benefit period
- none Hospice services
- \$40 per visit Habilitation services
- \$40 per visit Outpatient rehabilitative services, including:
 - Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary
 - Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement
- none Inpatient rehabilitation
- none Home self-injectable medication, limited to a 30-day supply; insulin is covered under the prescription benefit
- Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
 - \$15 per visit • Acupuncture, up to 20 visits per year
 - \$15 per visit** • Chiropractic care, up to 20 visits per year