

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage For: Self | 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 ?	\$2,000 per calendar year	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, \$3,000 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 adult eye examinations and chiropractic 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	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	\$30/visit, after deductible	Not covered	None
	Specialist visit	\$30/visit, after deductible	Not covered	None
	Other practitioner office visit	\$30/visit, after deductible	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	\$10/visit, after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50/visit, after deductible	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, after deductible (30 day supply); Mail Order: \$20/prescription, after deductible (90 day supply)	Not covered	None
	Preferred brand drugs	Retail: \$30/prescription, after deductible (30 day supply); Mail Order: \$60/prescription, after deductible (90 day supply)	Not covered	None
	Non-preferred brand drugs	Retail: \$50/prescription, after deductible (30 day supply); Mail Order: \$100/prescription, after deductible (90 day supply)	Not covered	None
	Specialty drugs	10% (\$100 max for 30 day supply), after deductible	Not covered	None
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	\$150/visit, after deductible	Not covered	None
	Physician/surgeon fees	No charge, after deductible	Not covered	None

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If you need immediate medical attention	Emergency room services	\$100/visit, after deductible	\$100/visit, after deductible	Waived if admitted
	Emergency medical transportation	\$100/trip, after deductible	\$100/trip, after deductible	None
	Urgent care	\$30/visit, after deductible	\$30/visit, after deductible	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)	\$250/admission, after deductible	Not covered	None
	Physician/surgeon fee	No charge, after deductible	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	\$30/visit, after deductible	Not covered	None
	Mental/behavioral health inpatient services	\$250/admission, after deductible	Not covered	None
	Substance use disorder outpatient services	\$30/visit, after deductible	Not covered	None
	Substance use disorder inpatient services	\$250/admission, after deductible	Not covered	None
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$250/admission, after deductible	Not covered	None

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If you need help recovering or have other special health needs	Home health care	No charge, after deductible	Not covered	100 visits per calendar year
	Rehabilitation services	\$30/visit, after deductible	Not covered	None
	Habilitation services	\$30/visit, after deductible	Not covered	None
	Skilled nursing care	\$250/admission, after deductible	Not covered	100 days per benefit period
	Durable medical equipment	No charge, after deductible	Not covered	None
	Hospice service	No charge, after deductible	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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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage For: Self | **Plan Type:** HMO

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

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

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

Coverage For: Self | 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 \$5,125
- Patient pays \$2,415

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	\$265
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$2,415

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

- Amount owed to providers: \$5,400
- Plan pays \$2,679
- Patient pays \$2,721

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	\$2,000
Co-pays	\$390
Co-insurance	\$252
Limits or exclusions	\$79
Total	\$2,721

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Coverage Examples

Coverage For: Self | Plan Type: HMO

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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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage For: Self + Family | Plan Type: HMO



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Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$4,000 per calendar year	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, \$6,000 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 adult eye examinations and chiropractic 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	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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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage For: Self + Family | Plan Type: HMO



- **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	\$30/visit, after deductible	Not covered	None
	Specialist visit	\$30/visit, after deductible	Not covered	None
	Other practitioner office visit	\$30/visit, after deductible	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	\$10/visit, after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50/visit, after deductible	Not covered	None

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

<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, after deductible (30 day supply); Mail Order: \$20/prescription, after deductible (90 day supply)	Not covered	None
	Preferred brand drugs	Retail: \$30/prescription, after deductible (30 day supply); Mail Order: \$60/prescription, after deductible (90 day supply)	Not covered	None
	Non-preferred brand drugs	Retail: \$50/prescription, after deductible (30 day supply); Mail Order: \$100/prescription, after deductible (90 day supply)	Not covered	None
	Specialty drugs	10% (\$100 max for 30 day supply), after deductible	Not covered	None
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	\$150/visit, after deductible	Not covered	None
	Physician/surgeon fees	No charge, after deductible	Not covered	None

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If you need immediate medical attention	Emergency room services	\$100/visit, after deductible	\$100/visit, after deductible	Waived if admitted
	Emergency medical transportation	\$100/trip, after deductible	\$100/trip, after deductible	None
	Urgent care	\$30/visit, after deductible	\$30/visit, after deductible	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)	\$250/admission, after deductible	Not covered	None
	Physician/surgeon fee	No charge, after deductible	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	\$30/visit, after deductible	Not covered	None
	Mental/behavioral health inpatient services	\$250/admission, after deductible	Not covered	None
	Substance use disorder outpatient services	\$30/visit, after deductible	Not covered	None
	Substance use disorder inpatient services	\$250/admission, after deductible	Not covered	None
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$250/admission, after deductible	Not covered	None

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If you need help recovering or have other special health needs	Home health care	No charge, after deductible	Not covered	100 visits per calendar year
	Rehabilitation services	\$30/visit, after deductible	Not covered	None
	Habilitation services	\$30/visit, after deductible	Not covered	None
	Skilled nursing care	\$250/admission, after deductible	Not covered	100 days per benefit period
	Durable medical equipment	No charge, after deductible	Not covered	None
	Hospice service	No charge, after deductible	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"> • Acupuncture • Routine eye care for adults 	<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Bariatric surgery

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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:

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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.



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See the next page for important information about these examples.

**Having a baby
(normal delivery)**

- Amount owed to providers: \$7,540
- Plan pays \$3,125
- Patient pays \$4,415

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	\$4,000
Co-pays	\$265
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$4,415

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

- Amount owed to providers: \$5,400
- Plan pays \$1,107
- Patient pays \$4,293

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	\$4,000
Co-pays	\$0
Co-insurance	\$214
Limits or exclusions	\$79
Total	\$4,293

Questions: Call 1-888-563-2250 or visit us at www.westernhealth.com. If you aren't clear about any of the terms used in this form, see the Uniform Glossary at <http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>

Coverage Examples

Coverage For: Self + Family | Plan Type: HMO

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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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.

member responsibility DEDUCTIBLE

- \$2,000* Self-only coverage
- \$4,000* Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA will cover those services. After the deductible is met the applicable copayments will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services as noted below. The deductible is applied each calendar year. If you have family coverage, there is no single deductible amount for each family member; rather, the entire Family deductible must be met before WHA becomes responsible for providing covered services for any individual member in the family. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

- \$3,000 Self-only coverage
- \$6,000 Family coverage

The out-of-pocket maximum is the maximum total amount of copayments and deductibles that a member or the family must pay for covered services during any calendar year. If you have family coverage, there is no single out-of-pocket maximum for each family member; rather, the entire Family out-of-pocket maximum must be met before you do not have to pay any more copayments for that calendar year. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

- none Lifetime maximum

cost to member SERVICES NOT SUBJECT TO DEDUCTIBLE

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.

- none Vision examination
- none Hearing examination

IMPORTANT: Health savings accounts (HSAs) are complex financial products. This plan is a high-deductible health care plan. While there is no obligation to have an HSA, WHA recommends that you consult your tax or financial advisor to discuss the benefits and determine whether this plan and HSAs are a good choice for you.

cost to member **SERVICES SUBJECT TO DEDUCTIBLE**
 after deductible is met

Professional Services

- \$30 per visit Office visits, primary care physician (PCP)
- \$30 per visit Office visits, specialist
- \$30 per visit Family planning services

Outpatient Services

- Outpatient surgery
- \$30 per visit • Performed in office setting
- \$150 per visit • Performed in facility — facility fees
- none • Performed in facility — professional services
- none Dialysis, infusion therapy and radiation therapy
- \$10 per visit Laboratory tests, X-ray and diagnostic imaging
- \$50 per visit Imaging (CT/PET scans and MRIs)
- \$5 per visit Therapeutic injections, including allergy shots

Hospitalization Services

- \$250 per admission 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

Urgent and Emergency Services

- Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area
- \$30 per visit • Physician's office
- \$30 per visit • Urgent care center
- \$100 per visit • Emergency room — facility fees (waived if admitted)
- none • Emergency room — professional services
- \$100 per trip • Ambulance service as medically necessary or in a life-threatening emergency (including 911)

Prescription Coverage

- Walk-in pharmacy (30-day supply)
- \$10 • Tier 1 - Preferred generic medication
- \$30 • Tier 2 - Preferred brand name medication¹
- \$50 • Tier 3 - Non-preferred medication¹
- Mail order (up to 90-day supply)
- \$20 • Tier 1 - Preferred generic medication
- \$60 • Tier 2 - Preferred brand name medication¹
- \$100 • Tier 3 - Non-preferred medication¹

The following prescription medications are covered at no cost to the member (generic required if available): aspirin, prenatal vitamins, folic acid, fluoride for preschool age children, tobacco cessation medication and women's contraceptives.

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the member will only be responsible for paying the actual cost of the medication.

¹Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment.

cost to member **SERVICES SUBJECT TO DEDUCTIBLE**
after deductible is met

Durable Medical Equipment (DME)

- 20%* 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

- \$30 per visit • Office visit
- none • Outpatient services
- \$250 per admission • Inpatient hospital services, including detoxification — provided at a participating acute care facility
- \$250 per admission • 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
- \$250 per admission 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
- \$30 per visit Habilitation services
- \$30 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
- \$250 per admission Inpatient rehabilitation
- 10%* Home self-injectable medication, up to a maximum of \$100 per 30-day supply, limited to a 30-day supply; insulin is covered under the prescription benefit

cost to member **SERVICES NOT SUBJECT TO DEDUCTIBLE**

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

* Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service.

** Services are not subject to the deductible and copayments do not contribute to the medical out-of-pocket maximum.

MANAGING YOUR HIGH-DEDUCTIBLE PLAN

The deductible and annual out-of-pocket maximum apply only to the covered services described in this Copayment Summary. Copayments and deductibles for any benefits purchased separately as a rider, including but not limited to infertility benefits, do not apply to this deductible or annual out-of-pocket maximum.

When your copayments and deductible payments for the services described in this Copayment Summary have reached the annual out-of-pocket maximum, WHA will automatically provide you a document to show that you do not have to pay any more copayments or deductibles for covered services through the end of the calendar year.

To review amounts applied to your annual deductible and out-of-pocket maximum, simply access your accumulator through MyWHA at westernhealth.com.

If you have any questions about how much has been applied to your deductible or annual out-of-pocket maximum, or whether certain payments you have made apply to the annual out-of-pocket maximum, please call WHA Member Services.