Western Health Advantage: Premier 0/15/0 HMO Prime Rx 10/20/30-2X INF

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 deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500/Individual or $3,000/Family per calendar year plan	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 0 1 ders in 0 1 ders(plan)Tj0 g0 0 0 1 k,s thyu havetoy mket thir owne out-of-pocket limitfam out-of-pocket limithas beeny mt.r
a network provider?	Yes. See mywha.org/directory or call 1-888-563-2250 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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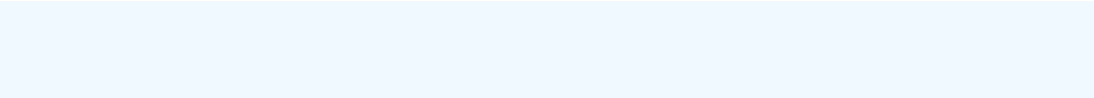
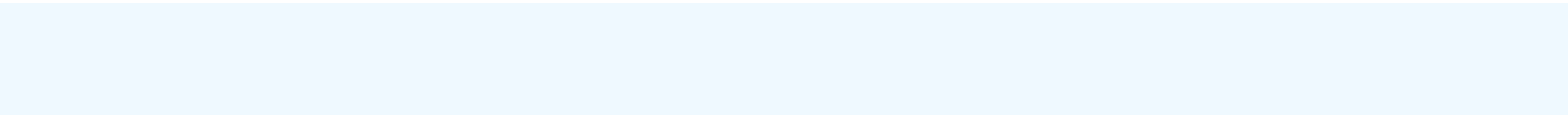
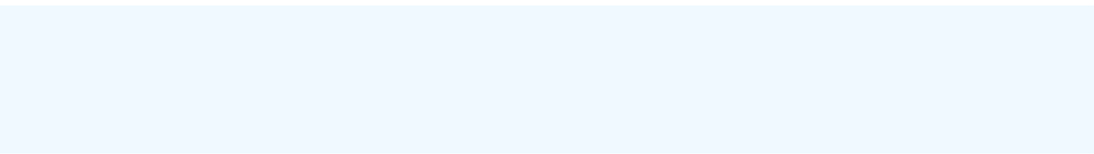
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	Not covered	None
	Specialist visit	$15/visit	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	For diagnostic tests, preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services. For imaging, preauthorization required. Failure to obtain preauthorization may result in non-payment of services.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at mywha.org/pharmacy	Tier 1 (Preferred generic and certain preferred brand name medications)	Retail: $10/prescription; Mail order: $20/prescription	Not covered	At Retail pharmacies, a 30-day supply is allowed; up to a 90-day supply is allowed through Mail Order. Preauthorization required for specialty medications, which are limited to a 30-day supply and must be obtained through WHA's specialty pharmacy network as described in the EOC/DF. Failure to obtain preauthorization may result in non-payment of services.
	Tier 2 (Preferred brand name or non-preferred generic medications)	Retail: $20/prescription; Mail order: $40/prescription	Not covered	
	Tier 3 (Non-preferred medications)	Retail: $30/prescription; Mail order: $60/prescription	Not covered	
	Self-injectable specialty drugs	20% coinsurance up to $100/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/visit	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visits per calendar year. Preauthorization required. Failure to obtain preauthorization may result in non-payment of services.
	Rehabilitation services	$15/visit	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services.
	Habilitation services	$15/visit	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services.
	Skilled nursing care	No charge	Not covered	100 days per calendar year. Preauthorization required. Failure to obtain preauthorization may result in non-payment of services.
	Durable medical equipment	20% coinsurance	Not covered	Preauthorization may be required. Failure to obtain preauthorization may result in non-payment of services.
	Hospice services	No charge	Not covered	Preauthorization required. Failure to obtain preauthorization may result in non-payment of services.
If your child needs dental or eye care	Children's eye exam	$15/visit	Not covered	One comprehensive eye exam per year (including dilation if medically indicated).
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care Adult
- Hearing Aids (u[illegible] purchased as a rider)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs (unless purchased as a rider)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion Services
- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care Adult

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

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Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable.

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TAGALOG

Kung ikaw, o ang iyong tinutulungan, 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.

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Western Health Advantage

888.563.2250 TTY 888.877.5378

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