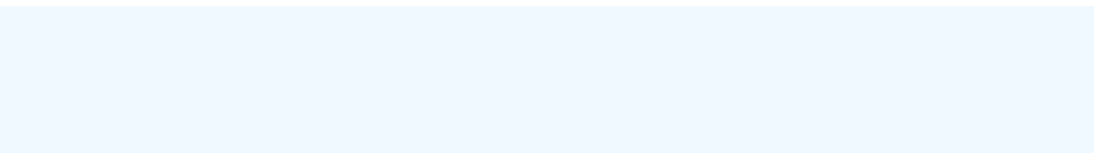
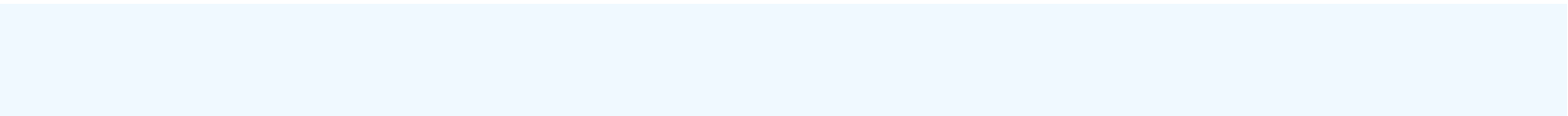
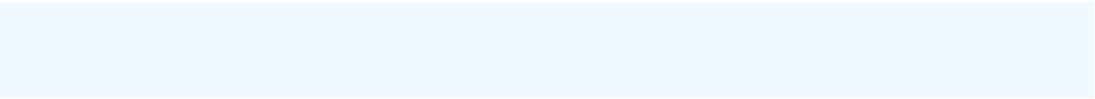
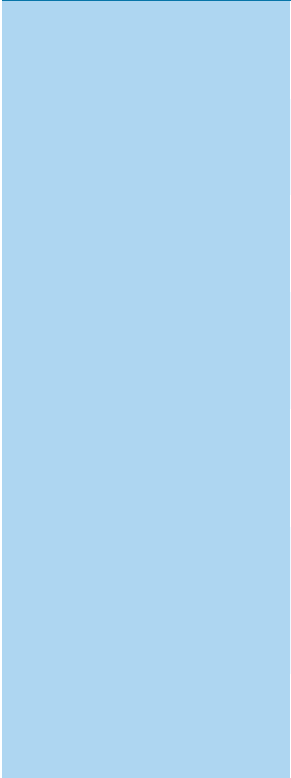


The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This 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](http://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](http://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> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	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="http://www.healthcare.gov/coverage/preventive-care-benefits">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> ?	\$1,500/Individual or \$3,000/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 the <a href="#">plan</a> , their <a href="#">out-of-pocket limit</a> may be different.
Is this <a href="#">plan</a> a <a href="#">network provider</a> ?	Yes. See <a href="http://mywha.org/directory">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> .

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	\$15/visit	Not covered	None
	<a href="#">Specialist</a> visit	\$15/visit	Not covered	<a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Preventive care/screening/immunization</a>	No charge	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)	No charge	Not covered	For <a href="#">diagnostic tests</a> , <a href="#">preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services. For imaging, <a href="#">preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> 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 <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: \$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. <a href="#">Preauthorization</a> 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 <a href="#">preauthorization</a> 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 <a href="#">specialty drugs</a>	20% <a href="#">coinsurance</a> 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	<a href="#">Home health care</a>	No charge	Not covered	100 visits per calendar year. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Rehabilitation services</a>	\$15/visit	Not covered	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Habilitation services</a>	\$15/visit	Not covered	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	100 days per calendar year. <a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> 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                           | • Long-Term Care                                     | • Routine Foot Care                                  |
| • Dental Care Adult                          | • Non-emergency care when traveling outside the U.S. | • Weight Loss Programs (unless purchased as a rider) |
| • Hearing Aids (unless purchased as a rider) | • Private-Duty Nursing                               |  |

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

- |                     |                     |                          |
|---------------------|---------------------|--------------------------|
| • Abortion Services | • Bariatric Surgery | • Infertility Treatment  |
| • Acupuncture       | • Chiropractic Care | • 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

\_\_\_\_\_

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.

! 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.

Western Health Advantage  
888.563.2250

TTY 888.877.5378

! " # \$%&' ( ) \* +#, (%-\* . / 012%&" 3%&2 45) /%- ) 267 8) , /#, %&2.  
+#, 2) =725, ) > <#?9%9@A) , 1\*) 2B. 8#5 =%4#<%& 8) \* ) , (?) 21) 8) , #l'

. \*) 4. 2 \$%&' . , ) 9%&2' %&2#' ) 29: ) , 012%&" 3%&2 ; 5#-#(%&' 3%&22#, 45) 2) <%&  
8) \*) , %9 ( ) \* 0 <4%- %&" 3) 2