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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes</td>
<td>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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,500/Individual or $2,500/Family per calendar year</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Member cost shares for infertility, adult vision exams, annual hearing exams, chiropractic care, and premiums and health care the plan doesn’t cover</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See mywha.org/directory or call 1-888-563-2250 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes</td>
<td>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.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least) $20/visit Out-of-Network Provider (You will pay the most) Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20/visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 (Preferred generic and certain preferred brand name medications)</td>
<td>Retail: $10/prescription; Mail order: $25/prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand name or non-preferred generic medications)</td>
<td>Retail: $30/prescription; Mail order: $75/prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred medications)</td>
<td>Retail: $50/prescription; Mail order: $125/prescription</td>
</tr>
<tr>
<td></td>
<td>Self-injectable specialty drugs</td>
<td>20% coinsurance up to $100/prescription</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100/visit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$125/visit (facility); No charge (professional)</td>
<td>$125/visit (facility); No charge (professional)</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$35/visit</td>
<td>$35/visit</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250/admission</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$20/visit (professional); No charge (other outpatient services)</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>$250/admission (facility); No charge (professional)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$250/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20/visit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20/visit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$250/admission</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$20/visit</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
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
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs
- Non-emergency care when traveling outside the U.S.
- Weight Loss Programs
- Routine Eye Care Adult

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

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

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.dmhc.ca.gov, or the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. Additionally, a consumer assistance program can help you file your appeal. For more information about your rights, this notice, or assistance, contact the California Department of Managed Health Care at 1-888-446-2219 or 1-888-877-5378 (TTY) or visit their website www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 credit 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.

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**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)
- **The Plan's overall Deductible**: $0
- **Specialist Copayment**: $20
- **Hospital (facility) Copayment**: $250
- **Other Copayment**: $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)*

**Total Example Cost**: $12,700

**In this example, Peg would pay:**
- **Cost Sharing**
  - Deductibles: $0
  - Copayments: $300
  - Coinsurance: $0

**What isn't covered**
- Limits or exclusions: $30

**The total Peg would pay is**: $330

The plan would be responsible for the other costs of these EXAMPLE covered services.

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
- **The Plan's overall Deductible**: $0
- **Specialist Copayment**: $20
- **Hospital (facility) Copayment**: $250
- **Other Copayment**: $20

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)*

**Total Example Cost**: $5,600

**In this example, Joe would pay:**
- **Cost Sharing**
  - Deductibles: $0
  - Copayments: $1,100
  - Coinsurance: $10

**What isn't covered**
- Limits or exclusions: $0

**The total Joe would pay is**: $1,110

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)
- **The Plan's overall Deductible**: $0
- **Specialist Copayment**: $20
- **Hospital (facility) Copayment**: $250
- **Other Copayment**: $20

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**: $2,800

**In this example, Mia would pay:**
- **Cost Sharing**
  - Deductibles: $0
  - Copayments: $300
  - Coinsurance: $0

**What isn't covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $300

The plan would be responsible for the other costs of these EXAMPLE covered services.
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. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

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 at 888.563.2250 and find more information online at 

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, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation age, or disability, you can file a grievance by telephone, mail, fax, email, or online 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, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, 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:

- Website: 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);

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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 quyền 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.
If you or someone you know needs help, you can call 888.563.2250 to speak with a representative of Western Health Advantage.

You can also call TTY 888.877.5378 if you have hearing or speech impairments.

If you need assistance in a language other than English, you can speak with a translator by calling 888.877.5378.

If you need assistance in another language, please call 888.563.2250.

For help in Korean, please call 888.563.2250.