

# WESTERN 2800/40/500 HDHP HMO PRIME

**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

- \$2,800\* Self-only coverage
- \$3,000\* Individual with Family coverage
- \$5,600\* Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA is responsible for covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or Family coverage amount, whichever is met first. Once the deductible is met, the relevant copayment(s) will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services, as noted below. Amounts paid for non-covered services do not count toward a member's deductible.

### ANNUAL OUT-OF-POCKET MAXIMUM

- \$4,000 Self-only coverage
- \$4,000 Individual with Family coverage
- \$8,000 Family coverage

The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. It includes the deductible and copayments. Once the deductible and copayment costs reach the annual out-of-pocket maximum, WHA will cover 100% of the covered services for the remainder of the 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

- none Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF. See additional benefit information at [mywha.org/preventive](http://mywha.org/preventive).

- 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: In order for a service to be considered "preventive," the service must be provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must be to obtain the preventive service. In the event you receive additional services that are not part of the preventive exam (for example, procedures or labs resulting from screenings or in response to your medical condition or symptoms), you will be responsible for the cost of those services as described in this copayment summary.

- none Vision examination
- none Hearing examination

## cost to member SERVICES SUBJECT TO DEDUCTIBLE

after deductible is met

### Professional Services

- \$40 per visit Office or virtual visit, primary care and other practitioners not listed below
- \$40 per visit Office or virtual visit, specialist
- \$40 per visit Family planning services

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

### Outpatient Services

Outpatient surgery

- |                 |  |
|-----------------|--|
| \$40 per visit  | • Performed in office setting                                  |
| \$250 per visit | • Performed in facility — facility fees                        |
| none            | • Performed in facility — professional services                |
| none            | Dialysis, chemotherapy, infusion therapy and radiation therapy |
| none            | Laboratory tests, X-ray and diagnostic imaging                 |
| none            | Imaging (CT/PET scans and MRIs)                                |
| \$5 per visit   | Therapeutic injections, including allergy shots                |

### Hospitalization Services

- |               |   |
|---------------|---|
| \$500 per day | 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

- |                 |   |
|-----------------|---|
| \$40 per visit  | • Physician's office or virtual visit   |
| \$45 per visit  | • Urgent care virtual visit   |
| \$50 per visit  | • Urgent care center  |
| \$100 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

Walk-in pharmacy (30-day supply)

- |      |   |
|------|---|
| \$10 | • Tier 1 - Preferred generic and certain preferred brand name medication                  |
| \$30 | • Tier 2 - Preferred brand name and certain non-preferred generic medication <sup>1</sup> |
| \$50 | • Tier 3 - Non-preferred (generic or brand) medication <sup>1</sup>                       |

Mail order (up to 90-day supply)

- |       |   |
|-------|---|
| \$25  | • Tier 1 - Preferred generic and certain preferred brand name medication                  |
| \$75  | • Tier 2 - Preferred brand name and certain non-preferred generic medication <sup>1</sup> |
| \$125 | • Tier 3 - Non-preferred (generic or brand) medication <sup>1</sup>                       |

Other Prescription Coverage

- |      |   |
|------|---|
| 20%* | Home self-injectable medication, up to \$100 maximum per 30-day supply  |
| 50%* | Erectile Dysfunction medication <sup>1</sup> , up to \$250 maximum per 30-day supply  |
| none | Aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication and women's contraceptives; generic required if available |

Members will pay the lesser of the applicable copayment, the actual cost, or the retail price of the prescription.

Non-injectable specialty medication may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply.

<sup>1</sup>Regardless 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
- \$40 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 Use Disorders

- \$40 per visit • Office or virtual visit
- none • Outpatient other services
- \$500 per day • Inpatient hospital services, including detoxification — provided at a participating acute care facility
- \$125 per day • Inpatient hospital services — provided at residential treatment center
- none • Inpatient professional services, including physician services

**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
- \$500 per day 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 calendar year
- 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
- \$500 per day Inpatient rehabilitation
- none Abortion and abortion-related service, including pre-abortion and follow-up services
- Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at [mywha.org](http://mywha.org).
- none • Acupuncture, up to 20 visits per year
- none • Chiropractic care, up to 20 visits per year

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

\*\* The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

**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.

**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 you reach your annual out-of-pocket maximum described in this Copayment Summary, WHA will mail you a letter to inform you 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.org](http://mywha.org). 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.



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> ?	\$3,000/Individual or \$5,600/Family per calendar year (\$2,800 if enrolled as single-only)	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, including <a href="#">preventive care</a> , and annual hearing and adult vision exams	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> ?	\$4,000/Individual or \$8,000/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 this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> and health care the plan doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use 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> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

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	\$40/visit	Not covered	None
	<a href="#">Specialist</a> visit	\$40/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; <a href="#">deductible</a> does not apply	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="http://mywha.org/pharmacy">mywha.org/pharmacy</a>	Tier 1 (Preferred generic and certain preferred brand name medications)	Retail: \$10/prescription; Mail order: \$25/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: \$30/prescription; Mail order: \$75/prescription	Not covered	
	Tier 3 (Non-preferred medications)	Retail: \$50/prescription; Mail order: \$125/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)	\$250/visit	Not covered	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	Physician/surgeon fees	No charge	Not covered	<a href="#">Preauthorization</a> required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.

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 immediate medical attention	<a href="#">Emergency room care</a>	\$100/visit (facility); No charge (professional)	\$100/visit (facility); No charge (professional)	Member cost shares for <a href="#">emergency room care</a> are waived if admitted. At <a href="#">urgent care</a> centers, services from an <a href="#">out-of-network provider</a> are covered only when obtained outside the service area. <a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	
	<a href="#">Urgent Care Center</a>	\$50/visit	\$50/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500/day	Not covered	<a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	Physician/surgeon fees	No charge	Not covered	<a href="#">Preauthorization</a> may be required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40/visit (professional); No charge (other outpatient services)	Not covered	<a href="#">Preauthorization</a> required for outpatient mental health and residential treatment center. <a href="#">Preauthorization</a> may be required for inpatient mental health. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	Inpatient services	\$500/day (facility); \$125/day (residential treatment center); No charge (professional)	Not covered	
If you are pregnant	Office visits	No charge; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , including routine prenatal care and first postnatal visit. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. <a href="#">Preauthorization</a> may be required for inpatient services. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$500/day	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>	\$40/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>	\$40/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>	\$500/day	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	No charge; <a href="#">deductible</a> does not apply	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                           | • Infertility Treatment                              | • Private-Duty Nursing                               |
| • Dental Care Adult                          | • Long-Term Care                                     | • Routine Foot Care                                  |
| • Hearing Aids (unless purchased as a rider) | • Non-emergency care when traveling outside the U.S. | • 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 | • Bariatric Surgery | • Routine Eye Care Adult |
| • Acupuncture       | • Chiropractic Care |                          |

**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](http://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](http://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](http://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](http://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.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>	\$3,000	■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>	\$3,000	■ The <a href="#">Plan's</a> overall <a href="#">Deductible</a>	\$3,000
■ <a href="#">Specialist Copayment</a>	\$40	■ <a href="#">Specialist Copayment</a>	\$40	■ <a href="#">Specialist Copayment</a>	\$40
■ Hospital (facility) Daily <a href="#">Copayment</a>	\$500	■ Hospital (facility) Daily <a href="#">Copayment</a>	\$500	■ Hospital (facility) Daily <a href="#">Copayment</a>	\$500
■ Other <a href="#">Copayment</a>	\$40	■ Other <a href="#">Copayment</a>	\$40	■ Other <a href="#">Copayment</a>	\$40
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$3,000	Deductibles	\$3,000	Deductibles	\$2,800
Copayments	\$1,000	Copayments	\$700	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$20	Limits or exclusions	\$0	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,020</b>	<b>The total Joe would pay is</b>	<b>\$3,700</b>	<b>The total Mia would pay is</b>	<b>\$2,800</b>

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

<https://www.westernhealth.com/legal/non-discrimination-notice/>.

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](mailto: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); Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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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 thêm 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.

**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.

**KOREAN**

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

**ARMENIAN**

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

**PERSIAN-FARSI**

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث آدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفاً با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره 888.877.5378 پیام تاییپی ارسال کنند

**RUSSIAN**

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

**JAPANESE**

ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

**ARABIC**

إن كان لديك أو لدى شخص تساعدُه أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

**PUNJABI**

ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਆਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

**CAMBODIAN-MON-KHMER**

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន នៅក្នុងភាសាបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកឆ្លន តាមលេខ 888.877.5378។

**HMONG**

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

**HINDI**

यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुआशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

**THAI**

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378