BENEFIT COMPARISON

Western Health Advantage

Plans for Individuals and Families

All individual plans from Western Health Advantage include the **Ten Essential Health Benefits** and comply with the **metal tiers** established by the Affordable Care Act [ACA]. The essential health benefits include:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Services and devices: help with recovery from an injury, disability or chronic condition
8. Laboratory services
9. Preventive services: counseling, screenings and vaccines
10. Pediatric services: dental and vision care for kids

The metal-tier system, which designates a plan as bronze, silver, gold or platinum, helps you compare options.

advantage you

CHOOSE A PLAN THAT WORKS FOR YOU >

Individual Plan Benefit Comparison

ADVANTAGE SERIES (outside exchange) COVERED CALIFORNIA PLANS		WHA PLATINUM 90 HMO	WHA GOLD 80 HMO	WHA SILVER 70 HMO	WHA BRONZE 60 HMO
		TRADITIONAL PLANS		DEDUCTIBLE PLANS	
MEDICAL DEDUCTIBLE[1]	SELF-ONLY COVERAGE	None	None	$2,250	$6,000
	INDIVIDUAL WITH FAMILY	None	None	$2,250	$6,000
	FAMILY COVERAGE	None	None	$4,500	$12,000
PRESCRIPTION DEDUCTIBLE[1]	SELF-ONLY COVERAGE	None	None	$250	$500
	INDIVIDUAL WITH FAMILY	None	None	$250	$500
	FAMILY COVERAGE	None	None	$500	$1,000
ANNUAL OUT-OF-POCKET MAXIMUM[2]	SELF-ONLY COVERAGE	$4,000	$6,200	$6,250	$6,500
	INDIVIDUAL WITH FAMILY	$4,000	$6,200	$6,250	$6,500
	FAMILY COVERAGE	$8,000	$12,400	$12,500	$13,000
PREVENTIVE CARE SERVICES[3, 4]					
Annual physical examinations		Covered in Full		Covered in Full	
Immunizations, adult and pediatric					
Women's preventive services					
Maternity care, routine prenatal and lab tests and first post-natal visit					
Well baby care					
Breast, cervical, prostate and colorectal cancer screenings					
PROFESSIONAL/OUTPATIENT SERVICES[3]					
Office visits, primary care		$20 per visit	$35 per visit	$45 per visit	$70 per visit*[10]
Office visits, specialist		$40 per visit	$55 per visit	$70 per visit	$90 per visit*
Outpatient surgery, facility		$250 per visit	$600 per visit	20%[11]	100%*
Outpatient surgery, professional		$40 per visit	$55 per visit	20%[11]	100%*
Laboratory tests		$20 per visit	$35 per visit	$35 per visit	$40 per visit
X-ray and diagnostic imaging		$40 per visit	$50 per visit	$65 per visit	100%*
Imaging (CT/PET scans and MRIs)		$150 per visit	$250 per visit	$250 per visit	100%*
HOSPITALIZATION SERVICES					
Hospital inpatient, facility		$250 per day, days 1-5	$600 per day, days 1-5	20%*[11]	100%*
Hospital inpatient, professional		$40 per visit	$55 per visit	20%*[11]	100%*
BEHAVIORAL HEALTH SERVICES Mental Health and Substance Abuse					
Office visits		$20 per visit	$35 per visit	$45 per visit	$70 per visit*[10]
Outpatient services		$20 per visit	$35 per visit	$45 per visit	$70 per visit*[10]
Inpatient, facility		$250 per day, days 1-5	$600 per day, days 1-5	20%*[11]	100%*
Inpatient, professional		$40 per visit	$55 per visit	20%*[11]	100%*
OTHER SERVICES					
Emergency room, facility (waived if admitted)		$150 per visit	$250 per visit	$250 per visit*	100%*
Emergency room, professional (waived if admitted)		Covered In Full	Covered in Full	$50*	100%*
Urgent care center		$40 per visit	$60 per visit	$90 per visit	$120 per visit*[10]
Ambulance services		$150 per trip	$250 per trip	$250 per trip*	100%*
Durable medical equipment[5]		10%[11]	20%[11]	20%[11]	100%*
Home health services, up to 100 visits		$20 per visit	$30 per visit	$45 per visit	100%*
Acupuncture[6]		$15 per visit	$15 per visit	$15 per visit	$15 per visit*
Pediatric vision, up to age 19[7]		Examination and eyewear at no cost; see additional benefit information			
Pediatric dental, up to age 19[8]		Diagnostic and preventive dental care at no cost; see additional benefit information			
PRESCRIPTION SERVICES[9]					
Tier 1 — preferred generic medication		$5	$15	$15	100% up to $500/month*
Tier 2 — preferred brand name medication		$15	$50	$50*	100% up to $500/month*
Tier 3 — non-preferred medication		$25	$70	$70*	100% up to $500/month*
Tier 4 — specialty medication		10%, up to $250/month[11]	20%, up to $250/month[11]	20%, up to $250/month*[11]	100%, up to $500/month*

*After Deductible — Copayment applies once deductible is met | See back page for applicable notes

FOR THOSE AGE 30 AND UNDER WHO DO NOT QUALIFY FOR TAX CREDIT				FOR THOSE WITH INCOME RANGE OF 100% – 150% FPL	FOR THOSE WITH INCOME RANGE OF 150% – 200% FPL	FOR THOSE WITH INCOME RANGE OF 200% – 250% FPL
				AVAILABLE FROM COVERED CALIFORNIA ONLY		
WHA MINIMUM COVERAGE HMO	**WHA BRONZE 60 HSA HMO**	**WHA SILVER 3350 HSA HMO**	**WHA BRONZE 6000 HSA HMO**	**WHA SILVER 94 HMO**	**WHA SILVER 87 HMO**	**WHA SILVER 73 HMO**
		AVAILABLE DIRECT FROM WHA ONLY				
DEDUCTIBLE PLAN	**HSA-COMPATIBLE HIGH-DEDUCTIBLE PLANS[12]**			**COST SHARING REDUCTION PLANS**		
$6,850	$4,500	$3,350	$6,000	$75	$550	$1,900
$6,850	$4,500	$3,350	$6,000	$75	$550	$1,900
$13,700	$9,000	$6,700	$12,000	$150	$1,100	$3,800
Included in the medical deductible	Included in the medical deductible	Included in the medical deductible	Included in the medical deductible	None	$50	$250
				None	$50	$250
				None	$100	$500
$6,850	$6,500	$3,350	$6,000	$2,250	$2,250	$5,450
$6,850	$6,500	$3,350	$6,000	$2,250	$2,250	$5,450
$13,700	$13,000	$6,700	$12,000	$4,500	$4,500	$10,900
Covered in Full	Covered in Full			Covered in Full		
Covered in Full*[12]	40%*[11]	Covered in Full*	Covered in Full*	$5 per visit	$15 per visit	$40 visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$8 per visit	$25 per visit	$55 per visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%[11]	15%[11]	20%[11]
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%[11]	15%[11]	20%[11]
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$8 per visit	$15 per visit	$35 per visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$8 per visit	$25 per visit	$50 per visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$50 per visit	$100 per visit	$250 per visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%*[11]	15%*[11]	20%*[11]
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%*[11]	15%*[11]	20%*[11]
Covered in Full*[12]	40%*[11]	Covered in Full*	Covered in Full*	$5 per visit	$15 per visit	$40 per visit
Covered in Full*[12]	40%*[11]	Covered in Full*	Covered in Full*	$5 per visit	$15 per visit	$40 per visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%*[11]	15%*[11]	20%*[11]
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%*[11]	15%*[11]	20%*[11]
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$30 per visit*	$75 per visit*	$250 per visit*
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$25 per visit*	$40 per visit*	$50 per visit*
Covered in Full*[12]	40%*[11]	Covered in Full*	Covered in Full*	$6 per visit	$30 per visit	$80 per visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$30 per trip*	$75 per trip*	$250 per trip*
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%[11]	15%[11]	20%[11]
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$3 per visit	$15 per visit	$40 per visit
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$5 per visit	$15 per visit	$15 per visit
Examination and eyewear at no cost; see additional benefit information						
Diagnostic and preventive dental care at no cost; see additional benefit information						
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$3	$5	$15
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$10	$20*	$45*
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	$15	$35*	$70*
Covered in Full*	40%*[11]	Covered in Full*	Covered in Full*	10%, up to $150/month*[11]	15%, up to $150/month*[11]	20%, up to $250/month*[11]

*After Deductible — Copayment applies once deductible is met | See back page for applicable notes

Western Health Advantage

westernhealth.com
888.563.2250 toll-free

MAIN OFFICE
2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833

NORTH BAY SALES OFFICE
4 Hamilton Landing, Suite 100
Novato, California 94949

This benefit comparison is intended to be used as a summary only.

The applicable Copayment Summary and Combined Evidence of Coverage and Disclosure Form (EOC/DF) should be consulted for a detailed description of coverage benefits and limitations. Applicants have a right to review the EOC/DF prior to enrollment. A copy may be requested by calling 888.563.2250 or via email at individualsales@westernhealth.com.

FOOTNOTES

1 Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.

2 The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.

3 Generally, all non-emergency care must be accessed through your primary care physician (PCP) within WHA's provider network. Obstetrical and gynecological services may be obtained directly without a PCP referral.

4 There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.

5 See Copayment Summary for applicable prosthetic/orthotic device copayment amount.

6 Acupuncture services provided through Landmark Healthplan of California.

7 Pediatric eyewear provided through MESVision.

8 Provided through Access Dental Plan, including: Diagnostic and preventive dental care at no cost, basic dental care services, major dental care services, orthodontics when determined medically necessary.

9 Certain drugs may be categorized outside their respective tier. To confirm the tier level for any drug, refer to the Preferred Drug List (PDL). Oral anti-cancer drugs will not exceed $200 for 30-day supply.

10 Deductible is waived for first three non-preventive office or urgent care visits in a calendar year.

11 Percentage copayment amounts are based on WHA's contracted rate.

12 The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the Individual amount or the family must meet the Family amount before benefits will apply for that member.

PUBLISHED JANUARY 2016
WHA 990 1.16