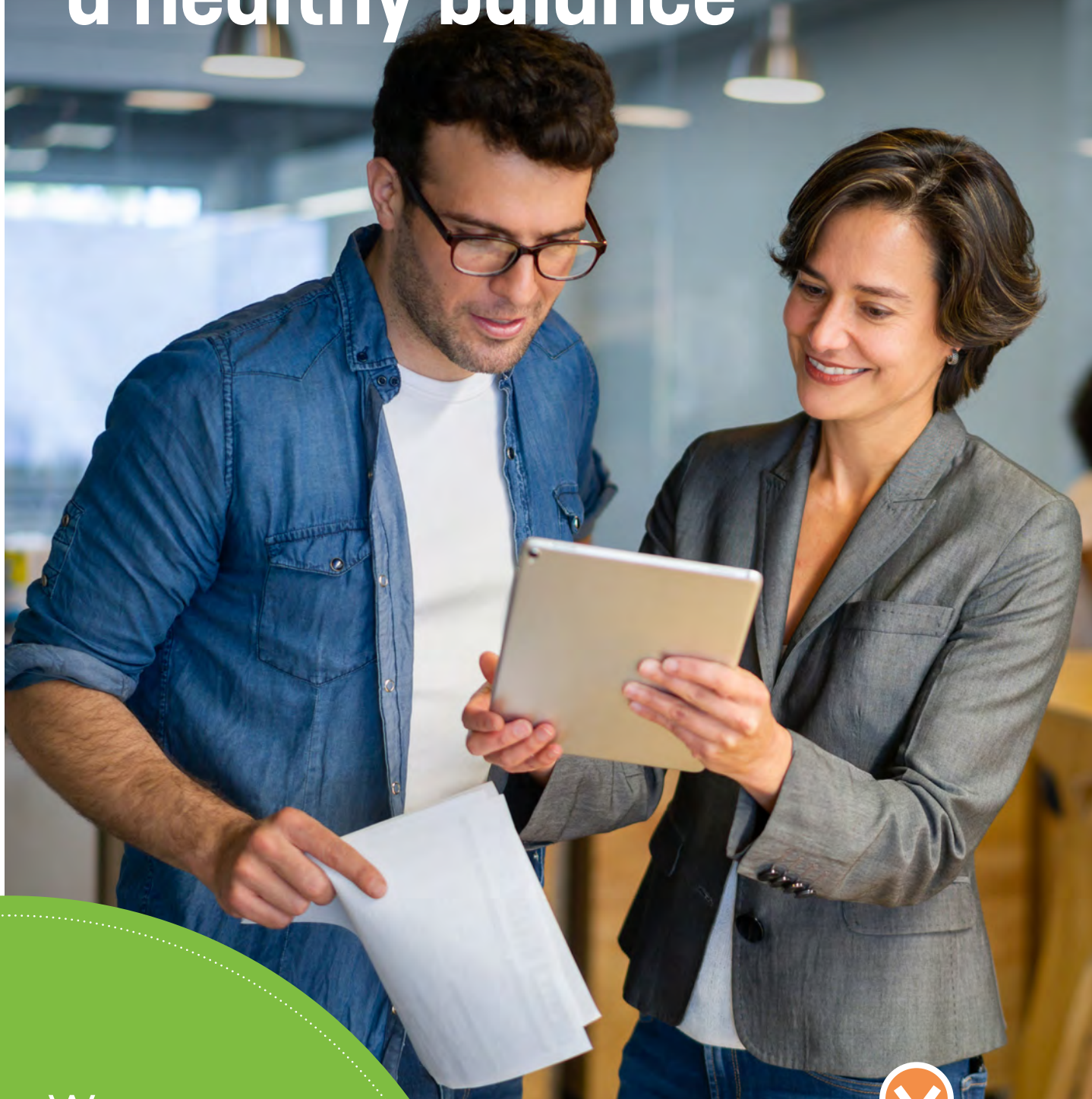


a healthy balance



Western
Health
Advantage



Plan Comparison

FOR LARGE GROUP
(100+ EMPLOYEES)

PLANS EFFECTIVE 01.01.23



robust yet flexible plan choices

Our range of plans offer flexible options that offer a sense of balance between your employees' health care needs and your budget. Our commitment is to always make health care work even better by finding that right balance with the right plan.

We offer a slate of robust plans for large group employers, allowing you to tailor plan options, whether you are a school district, municipality or mid-sized company.



WHA offers employers three types of plans

- Traditional (fixed copays without reaching a deductible first)
- Deductible (fixed costs for office visits with some services needing a deductible)
- HSA-compatible high-deductible (when bundled with a health savings account, HDHPs allow members to build funds to pay for out-of-pocket expenses).

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 888.499.3198 or via email at whasales@westernhealth.com.

BENEFIT COMPARISON

PREMIER PLANS

Copayment/coinsurance is listed per visit/per trip/per prescription

BENEFIT COMPARISON		PREMIER TRADITIONAL PLANS			
PREMIER PLANS		0/10/0 HMO PRIME	0/15/0 HMO PRIME	0/20/0 HMO PRIME	0/40/0 HMO PRIME
Copayment/coinsurance is listed per visit/per trip/per prescription					
MEDICAL DEDUCTIBLE¹	SELF-ONLY COVERAGE	none			
	INDIVIDUAL WITH FAMILY				
	FAMILY COVERAGE				
PRESCRIPTION DEDUCTIBLE¹	SELF-ONLY COVERAGE	n/a			
	INDIVIDUAL WITH FAMILY				
	FAMILY COVERAGE				
ANNUAL OUT-OF-POCKET MAXIMUM²	SELF-ONLY COVERAGE	\$1,000	\$1,500	\$1,500	\$1,500
	INDIVIDUAL WITH FAMILY	\$1,000	\$1,500	\$1,500	\$1,500
	FAMILY COVERAGE	\$2,500	\$2,500	\$2,500	\$2,500
PREVENTIVE CARE SERVICES³, 4					
Preventive Care is Covered in Full (CIF) — includes: annual physical examinations; immunizations, adult and pediatric; women’s preventive services; maternity care, routine prenatal and lab tests and first post-natal visit; well baby care; and breast, cervical, prostate and colorectal cancer screenings					
PROFESSIONAL/OUTPATIENT SERVICES³					
Office or virtual visits		\$10	\$15	\$20	\$40
Annual eye and hearing exams⁷		\$10	\$15	\$20	\$40
Outpatient surgery (performed in office setting)		\$10	\$15	\$20	\$40
Outpatient surgery (facility)		\$100	\$100	\$100	\$100
Laboratory test, x-rays and diagnostic imaging		CIF	CIF	CIF	CIF
Imaging (CT/PET scans and MRIs)		CIF	CIF	CIF	CIF
HOSPITALIZATION SERVICES					
Hospital inpatient, facility		CIF	CIF	CIF	CIF
Hospital inpatient, professional		CIF	CIF	CIF	CIF
BEHAVIORAL HEALTH SERVICES Mental Health & Substance Use Disorders					
Office or virtual visits		\$10	\$15	\$20	\$40
Outpatient other services		CIF	CIF	CIF	CIF
Inpatient services		CIF	CIF	CIF	CIF
OTHER SERVICES					
Emergency room (waived if admitted)		\$100	\$100	\$100	\$100
Urgent care virtual visit/Urgent care center		\$15/\$20	\$20	\$25/\$35	\$45/\$50
Ambulance services		CIF	CIF	CIF	CIF
Durable medical equipment⁸		20%⁶	20%⁶	20%⁶	20%⁶
Acupuncture care, up to 20 visits⁹		\$15	\$15	\$15	\$15
Chiropractic care, up to 20 visits⁹		\$15	\$15	\$15	\$15
PRESCRIPTION DRUG PLAN					
Retail Pharmacy (30-day supply) TIER 1		see prescription drug plans			
Retail Pharmacy (30-day supply) TIER 2					
Retail Pharmacy (30-day supply) TIER 3					
OTHER PRESCRIPTION COVERAGE					
Home self-injectable medication (30-day supply)		20% up to \$100⁶	20% up to \$100⁶	20% up to \$100⁶	20% up to \$100⁶

BENEFIT COMPARISON

ADVANTAGE PLANS

Copayment/coinsurance is listed per visit/per trip/per prescription

ADVANTAGE TRADITIONAL PLANS

MEDICAL DEDUCTIBLE ¹	SELF-ONLY COVERAGE	none					
	INDIVIDUAL WITH FAMILY						
	FAMILY COVERAGE						
PRESCRIPTION DEDUCTIBLE ¹	SELF-ONLY COVERAGE	n/a					
	INDIVIDUAL WITH FAMILY						
	FAMILY COVERAGE						
ANNUAL OUT-OF-POCKET MAXIMUM ²	SELF-ONLY COVERAGE	\$1,500	\$1,500	\$2,500	\$2,500	\$3,000	\$3,000
	INDIVIDUAL WITH FAMILY	\$1,500	\$1,500	\$2,500	\$2,500	\$3,000	\$3,000
	FAMILY COVERAGE	\$2,500	\$2,500	\$4,500	\$4,500	\$5,000	\$5,000
PREVENTIVE CARE SERVICES ^{3, 4}							
Preventive Care is Covered in Full (CIF) — includes: annual physical examinations; immunizations, adult and pediatric; women’s preventive services; maternity care, routine prenatal and lab tests and first post-natal visit; well baby care; and breast, cervical, prostate and colorectal cancer screenings							
PROFESSIONAL/OUTPATIENT SERVICES ³							
Office or virtual visits		\$20	\$15/30 ⁵	\$25	\$20	\$20	\$40
Annual eye and hearing exams ⁷		\$20	\$15/30 ⁵	\$25	\$20	\$20	\$40
Outpatient surgery (performed in office setting)		\$20	\$15/30 ⁵	\$25	\$20	\$20	\$40
Outpatient surgery (facility)		\$100	\$100	\$100	\$100	30% ⁶	30% ⁶
Laboratory test, x-rays and diagnostic imaging		CIF	CIF	CIF	CIF	CIF	CIF
Imaging (CT/PET scans and MRIs)		CIF	CIF	CIF	CIF	CIF	CIF
HOSPITALIZATION SERVICES							
Hospital inpatient, facility		\$250/ admission	\$250/day, days 1 to 3	\$500/ admission	\$500/day, days 1 to 5	30% ⁶	30% ⁶
Hospital inpatient, professional		CIF	CIF	CIF	CIF	CIF	CIF
BEHAVIORAL HEALTH SERVICES Mental Health & Substance Use Disorders							
Office or virtual visits		\$20	\$15	\$25	\$20	\$20	\$40
Outpatient other services		CIF	CIF	CIF	CIF	CIF	CIF
Inpatient services		\$250/ admission	\$250/day, days 1 to 3	\$500/ admission	\$500/day, days 1 to 5	30% ⁶	30% ⁶
OTHER SERVICES							
Emergency room (waived if admitted)		\$100	\$100	\$100	\$100	\$100	\$100
Urgent care virtual visit/Urgent care center		\$25/\$35	\$20/\$50	\$30/\$35	\$25/\$35	\$25/\$50	\$45/\$50
Ambulance services		CIF	CIF	CIF	CIF	CIF	CIF
Durable medical equipment ⁸		20% ⁶	20% ⁶	20% ⁶	20% ⁶	20% ⁶	20% ⁶
Acupuncture care, up to 20 visits ⁹		\$15	\$15	\$15	\$15	\$15	\$15
Chiropractic care, up to 20 visits ⁹		\$15	\$15	\$15	\$15	\$15	\$15
PRESCRIPTION DRUG PLANS							
Retail Pharmacy (30-day supply) TIER 1		see prescription drug plans					
Retail Pharmacy (30-day supply) TIER 2							
Retail Pharmacy (30-day supply) TIER 3							
OTHER PRESCRIPTION COVERAGE							
Home self-injectable medication (30-day supply)		20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶

BENEFIT COMPARISON

WESTERN PLANS

Copayment/coinsurance is listed per visit/per trip/per prescription

WESTERN DEDUCTIBLE PLANS

1000/20/20%
HMO
PRIME

1000/40/500
HMO
PRIME

2500/20/500
HMO
PRIME

2500/40/500
HMO
PRIME

2500/0/30%
HMO
PRIME

4500/50/40%
HMO
PRIME

MEDICAL DEDUCTIBLE ¹	SELF-ONLY COVERAGE	\$1,000	\$1,000	\$2,500	\$2,500	\$2,500	\$4,500
	INDIVIDUAL WITH FAMILY	\$1,000	\$1,000	\$2,500	\$2,500	\$2,500	\$4,500
	FAMILY COVERAGE	\$2,000	\$2,000	\$5,000	\$5,000	\$5,000	\$9,000
PRESCRIPTION DEDUCTIBLE ¹	SELF-ONLY COVERAGE	n/a	\$150 brand or non-preferred	\$150 brand or non-preferred	\$150 brand or non-preferred	\$150 brand or non-preferred	n/a
	INDIVIDUAL WITH FAMILY						
	FAMILY COVERAGE						
ANNUAL OUT-OF-POCKET MAXIMUM ²	SELF-ONLY COVERAGE	\$3,000	\$4,000	\$5,000	\$5,000	\$5,000	\$6,350
	INDIVIDUAL WITH FAMILY	\$3,000	\$4,000	\$5,000	\$5,000	\$5,000	\$6,350
	FAMILY COVERAGE	\$6,000	\$8,000	\$10,000	\$10,000	\$10,000	\$12,700
PREVENTIVE CARE SERVICES ^{3, 4}							

Preventive Care is Covered in Full (CIF) — includes: annual physical examinations; immunizations, adult and pediatric; women's preventive services; maternity care, routine prenatal and lab tests and first post-natal visit; well baby care; and breast, cervical, prostate and colorectal cancer screenings

PROFESSIONAL/OUTPATIENT SERVICES ³							
	Office or virtual visits	\$20	\$40	\$20	\$40	\$0/40 ⁵	\$50
	Annual eye and hearing exams ⁷	\$20	\$40	\$20	\$40	\$0/40 ⁵	\$50
	Outpatient surgery (performed in office setting)	\$20	\$40	\$20	\$40	\$0/40 ⁵	\$50
	Outpatient surgery (facility)	\$250 AD	\$250 AD	\$250 AD	\$250 AD	30% AD ⁶	40% AD ⁶
	Laboratory test / X-rays and diagnostic imaging	CIF	CIF	CIF	CIF	CIF/\$15 AD	CIF AD
	Imaging (CT/PET scans and MRIs)	CIF	CIF	CIF	CIF	\$150 AD	CIF AD
HOSPITALIZATION SERVICES							
	Hospital inpatient, facility	20% AD ⁶	\$500/day AD	\$500/day AD	\$500/day AD	30% AD ⁶	40% AD ⁶
	Hospital inpatient, professional	20% AD ⁶	CIF	CIF	CIF	30% AD ⁶	40% AD ⁶
BEHAVIORAL HEALTH SERVICES Mental Health & Substance Use Disorders							
	Office or virtual visits	\$20	\$40	\$20	\$40	CIF	\$50
	Outpatient other services	CIF	CIF	CIF	CIF	CIF	CIF
	Inpatient services	20% AD ⁶	\$500/day AD	\$500/day AD	\$500/day AD	30% AD ⁶	40% AD ⁶
OTHER SERVICES							
	Emergency room (waived if admitted)	20% AD ⁶	\$100 AD	\$100 AD	\$100 AD	30% AD ⁶	40% AD ⁶
	Urgent care virtual visit/Urgent care center	\$25/\$50	\$45/\$50	\$25/\$50	\$45/\$50	\$0/\$50	\$49/\$50
	Ambulance services	CIF	CIF	CIF	CIF	CIF	40% AD ⁶
	Durable medical equipment ⁸	20% ⁶	20% ⁶	20% ⁶	20% ⁶	20% ⁶	40% AD ⁶
	Acupuncture care, up to 20 visits ⁹	\$15	\$15	\$15	\$15	\$15	\$15
	Chiropractic care, up to 20 visits ⁹	\$15	\$15	\$15	\$15	\$15	\$15
PRESCRIPTION DRUG PLANS							
	Retail Pharmacy (30-day supply) TIER 1	\$10	\$10	\$10	\$10	\$10	\$15
	Retail Pharmacy (30-day supply) TIER 2	\$30	\$30 AD	\$30 AD	\$30 AD	\$30 AD	\$50
	Retail Pharmacy (30-day supply) TIER 3	\$50	\$50 AD	\$50 AD	\$50 AD	\$50 AD	\$75
OTHER PRESCRIPTION COVERAGE							
	Home self-injectable medication (30-day supply)	20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶	20% up to \$100 ⁶

Large Group: Effective 01.01.23 | CIF — Covered In Full | AD: After Deductible — Copayment applies once deductible is met | See applicable notes

BENEFIT COMPARISON

WESTERN HIGH-DEDUCTIBLE PLANS

Copayment/coinsurance is listed per visit/per trip/per prescription

		WESTERN HSA-COMPATIBLE HIGH-DEDUCTIBLE PLANS					
		1800/0/0 HDHP HMO PRIME ¹⁰	2800/0/0 HDHP HMO PRIME ¹⁰	2800/40/500 HDHP HMO PRIME ¹⁰	3000/30/30% HDHP HMO PRIME ¹⁰	4000/40%/40% HDHP HMO PRIME ¹⁰	5500/0/0 HDHP HMO PRIME ¹⁰
MEDICAL DEDUCTIBLE ¹	SELF-ONLY COVERAGE	\$1,800	\$2,800	\$2,800	\$3,000	\$4,000	\$5,500
	INDIVIDUAL WITH FAMILY	\$3,000	\$3,000	\$3,000	\$3,000	\$4,000	\$5,500
	FAMILY COVERAGE	\$3,600	\$5,600	\$5,600	\$6,000	\$8,000	\$11,000
PRESCRIPTION DEDUCTIBLE ¹	SELF-ONLY COVERAGE	combined with medical					
	INDIVIDUAL WITH FAMILY						
	FAMILY COVERAGE						
ANNUAL OUT-OF-POCKET MAXIMUM ²	SELF-ONLY COVERAGE	\$3,600	\$2,800	\$4,000	\$6,350	\$6,350	\$5,500
	INDIVIDUAL WITH FAMILY	\$3,600	\$3,000	\$4,000	\$6,350	\$6,350	\$5,500
	FAMILY COVERAGE	\$7,200	\$5,600	\$8,000	\$12,700	\$12,700	\$11,000
PREVENTIVE CARE SERVICES ^{3, 4}							

Preventive Care is Covered in Full (CIF) — includes: annual physical examinations; immunizations, adult and pediatric; women's preventive services; maternity care, routine prenatal and lab tests and first post-natal visit; well baby care; and breast, cervical, prostate and colorectal cancer screenings

PROFESSIONAL/OUTPATIENT SERVICES ³							
Office or virtual visits		CIF AD	CIF AD	\$40 AD	\$30 AD	40% AD ⁶	CIF AD
Annual eye and hearing exams ⁷		CIF	CIF	CIF	CIF	CIF	CIF
Outpatient surgery (performed in office setting)		CIF AD	CIF AD	\$40 AD	\$30 AD	40% AD ⁶	CIF AD
Outpatient surgery (facility)		CIF AD	CIF AD	\$250 AD	30% AD ⁶	40% AD ⁶	CIF AD
Laboratory test, x-rays and diagnostic imaging		CIF AD	CIF AD	CIF AD	30% AD ⁶	40% AD ⁶	CIF AD
Imaging (CT/PET scans and MRIs)		CIF AD	CIF AD	CIF AD	30% AD ⁶	40% AD ⁶	CIF AD
HOSPITALIZATION SERVICES							
Hospital inpatient, facility		CIF AD	CIF AD	\$500/day AD	30% AD ⁶	40% AD ⁶	CIF AD
Hospital inpatient, professional		CIF AD	CIF AD	CIF AD	30% AD ⁶	40% AD ⁶	CIF AD
BEHAVIORAL HEALTH SERVICES Mental Health & Substance Use Disorders							
Office or virtual visits		CIF AD	CIF AD	\$40 AD	\$30 AD	40% AD ⁶	CIF AD
Outpatient other services		CIF AD	CIF AD	CIF AD	30% AD ⁶	40% AD ⁶	CIF AD
Inpatient services		CIF AD	CIF AD	\$500/day AD	30% AD ⁶	40% AD ⁶	CIF AD
OTHER SERVICES							
Emergency room (waived if admitted)		CIF AD	CIF AD	\$100 AD	30% AD ⁶	40% AD ⁶	CIF AD
Urgent care virtual visit/Urgent care center		CIF AD	CIF AD	\$45 AD/ \$50 AD	30% up to \$35 AD/ 30% AD ⁶	40% up to \$49 AD/ 40% AD ⁶	CIF AD
Ambulance services		CIF AD	CIF AD	CIF AD	30% AD ⁶	40% AD ⁶	CIF AD
Durable medical equipment ⁸		CIF AD	CIF AD	20% AD ⁶	30% AD ⁶	40% AD ⁶	CIF AD
Acupuncture care, up to 20 visits ⁹		CIF AD	CIF AD	CIF AD	CIF AD	CIF AD	CIF AD
Chiropractic care, up to 20 visits ⁹		CIF AD	CIF AD	CIF AD	CIF AD	CIF AD	CIF AD
PRESCRIPTION DRUG PLANS							
Retail Pharmacy (30-day supply) TIER 1		CIF AD	CIF AD	\$10 AD	\$10 AD	40% up to \$500 AD ⁶	CIF AD
Retail Pharmacy (30-day supply) TIER 2		\$30 AD	CIF AD	\$30 AD	\$30 AD		CIF AD
Retail Pharmacy (30-day supply) TIER 3		\$50 AD	CIF AD	\$50 AD	\$50 AD		CIF AD
OTHER PRESCRIPTION COVERAGE							
Home self-injectable medication (30-day supply)		CIF AD	CIF AD	20% up to \$100 AD ⁶	20% up to \$100 AD ⁶	40% up to \$500 AD ⁶	CIF AD

Large Group: Effective 01.01.23 | CIF — Covered In Full | AD: After Deductible — Copayment applies once deductible is met | See applicable notes

PRESCRIPTION DRUG PLANS

When offering a Premier or an Advantage plan, the employer selects a prescription plan to accompany the medical plan.

	Rx 10/30/50	Rx 10/40/60	Rx 10/30/50 Deductible
TIER 1	\$10	\$10	\$10
TIER 2	\$30	\$40	\$30, after \$150 deductible ¹
TIER 3	\$50	\$60	\$50, after \$150 deductible ¹

OPTIONAL RIDERS

Copayments do not contribute to the medical out-of-pocket maximum. See official plan documents for description of details, limitations and/or exclusions.

INFERTILITY SERVICES ¹¹	
Infertility services	50% benefit, subject to limitations

VISION PLANS ¹²	Full Service \$0	Full Service \$10	Eyewear Only \$0	Eyewear Only \$10
Copayment	none	\$10	none	\$10
Annual exam	12 months	12 months	n/a	n/a
Lenses ¹³	24 months	24 months	24 months	24 months
Frames	24 months	24 months	24 months	24 months
Contact lenses ¹³	24 months	24 months	24 months	24 months

WELLNESS COACHING PLANS ¹⁴	
Real Appeal® (weight loss)	personalized one-on-one telephonic coaching from experts specializing in weight loss [includes registered dieticians] and smoking cessation
Quit For Life® (smoking cessation)	
Complete Coaching includes access to both coaching programs	

HEARING AID PLANS ¹⁵		
Choice	\$1,000 allowance	allowance for instrument and ear molds; every 36 months; includes routine hearing exam
Select	TruHearing® Advanced (\$699/device copayment)	flat copayment based on hearing aid selection; up to two hearing aids every 12 months; includes routine hearing exam
	TruHearing® Premium (\$999/device copayment)	

NOTES

- 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 Primary Care Physician copayment/specialist copayment.
- ⁶ Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
- ⁷ With the exception of pediatric vision exams, copayments for vision and hearing examinations do not contribute to the out-of-pocket maximum.
- ⁸ See Copayment Summary for applicable prosthetic/orthotic device copayment amount.
- ⁹ Acupuncture and chiropractic services provided through Landmark Healthplan of California, Inc. Copayments for chiropractic services, if applicable, do not contribute to the medical OOP maximum.
- ¹⁰ The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the Individual with family amount or the family must meet the Family amount before benefits will apply for that member.
- ¹¹ Refer to the Infertility Benefits Copayment Summary for limitations and exclusions.
- ¹² Vision plans are underwritten and administered by MESVision.
- ¹³ Lenses are covered at a 12-month interval if the prescription change so indicates. Contact lenses are in lieu of lenses and frames. Refer to the Summary of Vision Benefits for plan details.
- ¹⁴ Coaching is administered by Optum Health.
- ¹⁵ Hearing aid services are administered by TruHearing. Costs you pay for hearing services, including hearing exam copayment and hearing aid costs, do not contribute to the out-of-pocket maximum.

Western
Health
Advantage



we are here to support optimum health

Count on us to take care of your employees and their families. We are one of the top three among 21 California health plans, consistently earning high scores in member satisfaction and health plan quality from state and national surveys. Additionally, nearly 94% of our clinical providers would recommend WHA to other physicians. You can easily reach us in person or on the phone. We're responsive and make decisions without delay.

Western Health Advantage is here to provide you exceptional, personal service. Choose WHA.



visit **choosewha.com**



916.563.3198

toll-free **888.499.3198**

TDD/TTY **888.877.5378**

2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833

advantage  **you**