

# WHA BRONZE 60 HMO



Western  
Health  
Advantage



advantage > you

## WHA BRONZE 60 HMO

Control how much you spend on health care expenses by paying for services when you need them. Pay a significantly lower monthly premium, and services like hospital visits and prescription medication are subject to a deductible.

### PLAN HIGHLIGHTS:

1. You don't pay for services you don't use.
2. Preventive care is included in your health plan at no cost. This means you will not have to pay for your annual well visits, immunizations or other preventive care services.
3. When you do need care, enjoy consistent savings on your health care services and supplies. Western Health Advantage partners with leading service providers to ensure that our members get the best negotiated rates available.

[LEARN MORE >](#)

## 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

The medical and prescription deductibles are the amount of money a member or family must pay for certain covered services before WHA is responsible for those covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or the Family coverage amount, whichever is met first.

**MEDICAL** — The deductible is waived for first three visits combined for non-preventive care, specialty care, urgent care, acupuncture and outpatient mental health/substance use disorder services.

|  |                                 |
|--|---------------------------------|
| \$6,300*                               | Self-only coverage              |
| \$6,300*                               | Individual with Family coverage |
| \$12,600*                              | Family coverage                 |
| <b>PRESCRIPTION (Rx) — Tiers 1 – 4</b> |                                 |
| \$500*                                 | Self-only coverage              |
| \$500*                                 | Individual with Family coverage |
| \$1,000*                               | Family coverage                 |

### member responsibility ANNUAL OUT-OF-POCKET MAXIMUM

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.

|          |                                 |
|----------|---------------------------------|
| \$6,800  | Self-only coverage              |
| \$6,800  | Individual with Family coverage |
| \$13,600 | Family coverage                 |
| none     | Lifetime maximum                |

### cost to member Preventive Care Services

none Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF

- 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: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered "preventive," the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in this copayment summary.

### Professional Services

|                                      |  |
|--------------------------------------|--|
| \$75 per visit after deductible      | Office visits, primary care and other practitioners not listed below |
| \$105 per visit after deductible     | Office visits, specialist  |
| none                                 | Pediatric vision examination, up to age 19                           |
| \$75/105 per visit after deductible+ | Family planning services   |

### cost to member Outpatient Services

|                                      |  |
|--------------------------------------|--|
| \$75/105 per visit after deductible+ | Outpatient surgery                               |
| 100% after deductible*               | • Performed in office setting                    |
| 100% after deductible*               | • Performed in facility — facility fees          |
| 100% after deductible*               | • Performed in facility — professional services  |
| \$40 per visit                       | Dialysis, infusion therapy and radiation therapy |
| 100% after deductible*               | Laboratory tests                                 |
| 100% after deductible*               | X-ray and diagnostic imaging                     |
| \$5 per visit                        | Imaging (CT/PET scans and MRIs)                  |
|                                      | Therapeutic injections, including allergy shots  |

### Hospitalization Services

|                        |   |
|------------------------|---|
| 100% after deductible* | 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 |
| 100% after deductible* | Professional inpatient services, including:   |
|                        | • Physicians' services, including surgeons, anesthesiologists and consultants   |
|                        | • Private-duty nurse when prescribed by a participating physician   |

### Urgent and Emergency Services

|                                      |  |
|--------------------------------------|--|
|                                      | Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area: |
| \$75/105 per visit after deductible+ | • Physician's office   |
| \$75 per visit after deductible      | • Urgent care center   |
| 100% after deductible*               | • Emergency room — facility fees ( if admitted)  |
| none                                 | • Emergency room — professional services   |
| 100% after deductible*               | • Ambulance service as medically necessary or in a life-threatening emergency (including 911)                  |

### Prescription Coverage

|  |  |
|--|--|
| 100% up to \$500 per prescription after Rx deductible* (Tiers 1 – 4)   | Walk-in pharmacy (30-day supply)   |
|  | • Tier 1 - Preferred generic and certain preferred brand name medication   |
|  | • Tier 2 - Preferred brand name or non-preferred generic medication <sup>1</sup>   |
|  | • Tier 3 - Non-preferred medication <sup>1</sup>   |
|  | • Tier 4 - Specialty medication when authorized in advance by WHA (access to Tier 4 medications at walk-in pharmacies is subject to limitations) |
| 100% up to \$1,250 per prescription after Rx deductible* (Tiers 1 – 3) | Mail order (up to 90-day supply)   |
|  | • Tier 1 - Preferred generic and certain preferred brand name medication   |
|  | • Tier 2 - Preferred brand name or non-preferred generic medication <sup>1</sup>   |
|  | • Tier 3 - Non-preferred medication <sup>1</sup>   |
| 100% up to \$500 per prescription after Rx deductible*                 | • Tier 4 - Specialty medication when authorized in advance by WHA, limited to a 30-day supply  |

Certain specialty drugs may be categorized outside Tier 4. To confirm the tier level for any drug, go online to [mywha.org/pharmacy](http://mywha.org/pharmacy); refer to the Preferred Drug List (PDL).

Oral anti-cancer drugs will not exceed \$200 after Rx deductible for 30-day supply.

The following prescription medications are covered at no cost to the member (generic required if available): aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication and women's contraceptives.

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the member will only be responsible for paying the actual cost of the medication.

<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 Durable Medical Equipment (DME)**

|                        |  |
|------------------------|--|
| 100% after deductible* | 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 |
| \$75 after deductible  | 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 Abuse

|   |  |
|---|--|
| \$75 per visit after deductible             | • Office visit   |
| 100% up to \$75 per visit after deductible* | • Outpatient services  |
| 100% after deductible*                      | • Inpatient hospital services, including detoxification — provided at a participating acute care facility  |
| 100% after deductible*                      | • Inpatient hospital services — provided at residential treatment center   |
| 100% after deductible*                      | • Inpatient professional services, including physician services  |
|   | Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED). |

**Other Health Services**

|                                    |   |
|------------------------------------|---|
| 100% after deductible*             | Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year   |
| 100% after deductible*             | 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 benefit period  |
| none                               | Hospice services  |
| \$75 per visit                     | Habilitation services   |
| \$75 per visit                     | Outpatient rehabilitative services, including: <ul style="list-style-type: none"> <li>• Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary</li> <li>• 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</li> </ul> |
| 100% after deductible*             | Inpatient rehabilitation  |
| \$75 per visit after deductible    | Acupuncture services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required   |
| none                               | Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, includes one of the following benefits: <ul style="list-style-type: none"> <li>• One pair of glasses with standard lenses</li> <li>• One pair of standard hard or six pairs of standard soft contact lenses instead of glasses</li> </ul>   |
| See additional benefit information | Pediatric dental, provided through DeltaCare® USA, up to age 19, including the following benefits: <ul style="list-style-type: none"> <li>• Diagnostic and preventive dental care at no cost</li> <li>• Basic dental care services</li> <li>• Major dental care services</li> <li>• Orthodontics when determined medically necessary</li> </ul>   |

+ Primary Care Physician Copayment \$75/Specialist Copayment \$105

\* Deductible or percentage copayments are based on WHA's contracted rates with the provider of service. Even when the deductible is met, members will pay 100% coinsurance for specified benefits until the out-of-pocket maximum is met.

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

**MANAGING YOUR HIGH-DEDUCTIBLE PLAN**

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 at [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.

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Western Health Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.

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, age, disability, or sex, you can file a grievance 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). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Member Services Manager is available to help you.

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 آدنیتیج) 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 تساعد أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية 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, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាននៅក្នុងភាសាប្រសំអ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធូន 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। दुभाशिए 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 หรือคนที่กำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้ TTY สำหรับคนหูหนวกโดยโทร 888.877.5378