



**westernhealth**  
**ADVANTAGE**



# WHA PLAN AT A GLANCE

Your employer has selected this plan for you.

**This is a summary only.** Consult the applicable Copayment Summaries and Combined Evidence of Coverage and Disclosure Form (EOC/DF) for a detailed description of coverage benefits and limitations. Applicants have a right to review the EOC/DF prior to enrollment. Call WHA Group Sales at 888.499.3198 to request a copy. Plan summaries are on your group's WHA web page.

<b>MEDICAL PLAN</b> <b>EFFECTIVE 01.01.26</b>	<b>PREMIER 0/30/0A</b> <b>HMO PRIME</b>
Medical Deductible (Self-Only/Individual/Family)	none
Prescription Deductible (Self-Only/Individual/Family)	none
Annual Out-of-pocket Max (Self-Only/Individual/Family)	\$1,500 • \$1,500 • \$3,000
<b>Preventive Care Services – Covered in Full</b> 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	
Office or virtual visits, primary care • specialist	\$30 • \$30
Annual vision exam <sup>1</sup> • hearing exam <sup>2</sup>	covered in full • \$30
Outpatient surgery (performed in office setting)	\$30
Outpatient surgery (facility)	\$100
Laboratory test • X-ray and diagnostic imaging	covered in full • covered in full
Imaging (CT/PET scans and MRIs)	covered in full
Hospital inpatient, facility (days) • professional	covered in full • covered in full
Behavioral health office or virtual visits	\$30
Behavioral health outpatient/inpatient services	covered in full
Emergency room, facility (waived if admitted) • professional	\$100 • covered in full
Urgent care virtual visit • Urgent care center	\$30 • \$30
Ambulance services	covered in full
Durable medical equipment	covered in full
Acupuncture • Chiropractic care <sup>2</sup> , up to 20 visits per year	\$15 • \$15
<b>INCLUDES PRESCRIPTION DRUG COVERAGE</b>	<b>RX 10/30/50/100</b>
TIER 1 — TIER 3 (Retail 30-day supply)	\$10 • \$30 • \$50
TIER 1 — TIER 3 (Home delivery 100-day supply)	\$20 • \$60 • \$100
TIER 4 (Specialty 30-day supply)	\$100

<sup>1</sup> When provided through Vision Service Plan (VSP) | <sup>2</sup> Copayments do not contribute to the medical out-of-pocket maximum

Elk Grove Unified School District



[choosewha.com/EGUSD](https://choosewha.com/EGUSD)

