



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.

MEDICAL PLAN COMPARISON EFFECTIVE 01.01.26	WESTERN 2800/0/0 HDHP HMO PRIME
Medical Deductible (Self-Only/Individual/Family)	\$2,800 • \$3,400 • \$5,600
Prescription Deductible (Self-Only/Individual/Family)	combined with medical
Annual Out-of-pocket Max (Self-Only/Individual/Family)	\$2,800 • \$3,400 • \$5,600
Preventive Care Services – Covered in Full 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	covered in full after deductible
Annual vision exam ¹ • hearing exam	covered in full
Outpatient surgery (performed in office setting)	covered in full after deductible
Outpatient surgery (facility)	covered in full after deductible
Laboratory test • X-ray and diagnostic imaging	covered in full after deductible
Imaging (CT/PET scans and MRIs)	covered in full after deductible
Hospital inpatient, facility • professional	covered in full after deductible
Behavioral health office or virtual visits	covered in full after deductible
Behavioral health outpatient/inpatient services	covered in full after deductible
Emergency room, facility (waived if admitted) • professional	covered in full after deductible
Urgent care virtual visit • Urgent care center	covered in full after deductible
Ambulance services	covered in full after deductible
Durable medical equipment	covered in full after deductible
Acupuncture • Chiropractic care, up to 20 visits per year	covered in full after deductible
INCLUDES PRESCRIPTION DRUG COVERAGE	INCLUDED IN MEDICAL
TIER 1 • TIER 2 • TIER 3 (Retail 30-day supply)	covered in full after deductible
TIER 1 • TIER 2 • TIER 3 (Home delivery 100-day supply)	covered in full after deductible
TIER 4 (Specialty 30-day supply)	covered in full after deductible

¹ Annual examinations for **adult vision**, when provided through Vision Service Plan (VSP)



choosewha.com/safecu

