westernhealth ADVANTAGE

WHA PLAN COMPARISON

Your employer has selected these plan options for you to choose from.

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 01.01.24	ACTIVE EMPLOYEES	EARLY RETIREES
	PREMIER 0/20/0 HMO PRIME	
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/$2,500	
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	$20 per visit	
Annual eye and hearing exams	$20 per visit	
Outpatient surgery (performed in office setting)	$20 per visit	
Outpatient surgery (facility)	$100 per visit	
Laboratory test, x-rays and diagnostic imaging	covered in full	
Imaging (CT/PET scans and MRIs)	covered in full	
Hospital inpatient, facility	covered in full	
Hospital inpatient, professional	covered in full	
Behavioral health office or virtual visits	$20 per visit	
Behavioral health outpatient services	covered in full	
Behavioral health inpatient services	covered in full	
Emergency room (waived if admitted)	$100 per visit	
Urgent care virtual visit/Urgent care center	$25/$35 per visit	
Ambulance services	covered in full	
Durable medical equipment	20%	
Pregnancy support/Pre-implantation genetic testing	50% (see Family & Diversity plan)	
Home self-injectable medication (30-day supply)	20% up to $100	
Acupuncture and Chiropractic care, up to 20 visits each	$15 per visit	
Infertility services	50% (see Infertility A)	none
Hearing aids	$1,000 per 36 months (see Hearing Aid 2 plan)	none
INCLUDES PRESCRIPTION DRUG COVERAGE	**RX 10/25/35-2X**	**RX 10/30/50**
TIER 1 / TIER 2 / TIER 3 (Retail 30-day supply)	$10/$25/$35	$10/$30/$50

learn more > choosewha.com/sjusd