GATEWAY 30 PLATINUM 90 HMO

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
none	Deductible amount

ANNUAL OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. Once 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.

$4,000	Self-only coverage
$4,000	Individual with Family coverage
$8,000	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

$30 per visit	Office visits, primary care and other practitioners not listed below
$30 per visit	Office visits, specialist
none	Adult vision examination
none	Pediatric vision examination, up to age 19
none	Hearing examination
$30 per visit	Family planning services

Outpatient Services

	Outpatient surgery
$30 per visit	• Performed in office setting
$100 per visit	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests
none	X-ray and diagnostic imaging
$150 per visit	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots

cost to member	
	Hospitalization Services
$300 per day, days 1-3	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
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:
$30 per visit	• Physician's office
$50 per visit	• Urgent care center
$150 per visit	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Walk-in pharmacy (30-day supply)
$5	• Tier 1 - Preferred generic and certain preferred brand name medication
$30	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$50	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 for a 30-day supply (access to Tier 4 medications at walk-in pharmacies is subject to limitations)
	Mail order (up to 90-day supply)
$12.50	• Tier 1 - Preferred generic and certain preferred brand name medication
$75	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$125	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 for a 30-day supply, 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; refer to the Preferred Drug List (PDL). Oral anti-cancer drugs will not exceed $200 for a 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. [1]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.**
	Durable Medical Equipment (DME)
20%*	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
$30	Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA

cost to member	Behavioral Health Services
	Mental Health Disorders and Substance Abuse
$30 per visit	• Office visit
none	• Outpatient services
$300 per day, days 1-3	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
$125 per day, days 1-3	• Inpatient hospital services — provided at a residential treatment center
none	• 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
none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
$300 per day, days 1-3	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
$30 per visit	Habilitation services
$30 per visit	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • 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
$300 per day, days 1-3	Inpatient rehabilitation
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
$15 per visit	• Acupuncture
$15 per visit***	• Chiropractic care, up to 20 visits per year
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, includes one of the following benefits: • One pair of glasses with standard lenses • One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, includes the following benefits: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

* Percentage copayments are based on WHA's contracted rates with the provider of service.
** The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.
*** Copayments do not contribute to the out-of-pocket maximum.

GATEWAY 70 PLATINUM 90 HMO

COPAYMENT SUMMARY a uniform health plan benefit and coverage matrix

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member responsibility	DEDUCTIBLE
none	Deductible amount

ANNUAL OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. Once 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.

$4,000	Self-only coverage
$4,000	Individual with Family coverage
$8,000	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

$20 per visit	Office visits, primary care and other practitioners not listed below
$20 per visit	Office visits, specialist
none	Adult vision examination
none	Pediatric vision examination, up to age 19
none	Hearing examination
$20 per visit	Family planning services

Outpatient Services

	Outpatient surgery
$20 per visit	• Performed in office setting
$100 per visit	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests
none	X-ray and diagnostic imaging
$150 per visit	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots

cost to member	
	Hospitalization Services
30%*	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
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:
$20 per visit	• Physician's office
$50 per visit	• Urgent care center
$150 per visit	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Walk-in pharmacy (30-day supply)
$5	• Tier 1 - Preferred generic and certain preferred brand name medication
$30	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$50	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 for a 30-day supply (access to Tier 4 medications at walk-in pharmacies is subject to limitations)
	Mail order (up to 90-day supply)
$12.50	• Tier 1 - Preferred generic and certain preferred brand name medication
$75	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$125	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 for a 30-day supply, 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; refer to the Preferred Drug List (PDL).
	Oral anti-cancer drugs will not exceed $200 for a 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.
	[1]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.**
	Durable Medical Equipment (DME)
20%*	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
$20	Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA

cost to member	Behavioral Health Services
	Mental Health Disorders and Substance Abuse
$20 per visit	• Office visit
none	• Outpatient services
30%*	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
30%*	• Inpatient hospital services — provided at a residential treatment center
none	• 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
none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
30%*	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
$20 per visit	Habilitation services
$20 per visit	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • 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
30%*	Inpatient rehabilitation
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
$15 per visit	• Acupuncture
$15 per visit***	• Chiropractic care, up to 20 visits per year
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, includes one of the following benefits: • One pair of glasses with standard lenses • One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, includes the following benefits: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

* Percentage copayments are based on WHA's contracted rates with the provider of service.
** The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.
*** Copayments do not contribute to the out-of-pocket maximum.

Western Health Advantage

GATEWAY 1500 SILVER 70 HDHP HMO

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
$1,500*	Self-only coverage
$2,700*	Individual with Family coverage
$3,000*	Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA is responsible for covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or Family coverage amount, whichever is met first. Once the deductible is met, the relevant copayment(s) will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services, as noted below. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

$6,550	Self-only coverage
$6,550	Individual with Family coverage
$13,100	Family coverage

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.

none	Lifetime maximum

cost to member	SERVICES NOT SUBJECT TO DEDUCTIBLE

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.

none	Adult vision examination
none	Hearing examination

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE

Professional Services

$20 per visit	Office visits, primary care and other practitioners not listed below
$20 per visit	Office visits, specialist
$20 per visit	Family planning services

GATEWAY 1500 SILVER 70 HDHP HMO

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE
	Outpatient Services
	Outpatient surgery
$20 per visit	• Performed in office setting
30%*	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests
none	X-ray and diagnostic imaging
30%*	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots
	Hospitalization Services
30%*	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
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area
$20 per visit	• Physician's office
$50 per visit	• Urgent care center
30%*	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Walk-in pharmacy (30-day supply)
$25	• Tier 1 - Preferred generic and certain preferred brand name medication
$50	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$75	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the deductible for a 30-day supply (access to Tier 4 medications at walk-in pharmacies is subject to limitations)
	Mail order (up to 90-day supply)
$62.50	• Tier 1 - Preferred generic and certain preferred brand name medication
$125	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$187.50	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the deductible for a 30-day supply, 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; refer to the Preferred Drug List (PDL).

Oral anti-cancer drugs will not exceed $200 after the deductible for a 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.

[1]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.**

Western Health Advantage

GATEWAY 1500 SILVER 70 HDHP HMO

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE
	Durable Medical Equipment (DME)
20%*	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
$20	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
$20 per visit	• Office visit
none	• Outpatient services
30%*	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
30%*	• Inpatient hospital services — provided at a residential treatment center
none	• 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
none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
30%*	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
$20 per visit	Habilitation services
$20 per visit	Outpatient rehabilitative services, including:
	• Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary
	• 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
30%*	Inpatient rehabilitation
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
none	• Acupuncture
none	• Chiropractic care, up to 20 visits per year

cost to member	ADDITIONAL HEALTH SERVICES — NOT SUBJECT TO DEDUCTIBLE
none	Pediatric vision examination, up to age 19
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, includes one of the following benefits:
	• One pair of glasses with standard lenses
	• One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, includes the following benefits:
	• Diagnostic and preventive dental care at no cost
	• Basic dental care services
	• Major dental care services
	• Orthodontics when determined medically necessary

* Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service
** 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

The deductible and annual out-of-pocket maximum apply only to the covered services described in this Copayment Summary. Copayments and deductibles for any benefits purchased separately as a rider, including but not limited to infertility benefits, do not apply to this deductible or annual out-of-pocket maximum. 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 through 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.

Western Health Advantage

GATEWAY 2000 GOLD 80 HDHP HMO

COPAYMENT SUMMARY a uniform health plan benefit and coverage matrix

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member responsibility	DEDUCTIBLE
$2,000*	Self-only coverage
$2,700*	Individual with Family coverage
$4,000*	Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA is responsible for covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or Family coverage amount, whichever is met first. Once the deductible is met, the relevant copayment(s) will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services, as noted below. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

$4,000	Self-only coverage
$4,000	Individual with Family coverage
$8,000	Family coverage

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.

none	Lifetime maximum

cost to member	SERVICES NOT SUBJECT TO DEDUCTIBLE

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.

none	Adult vision examination
none	Hearing examination

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE

Professional Services

none	Office visits, primary care and other practitioners not listed below
none	Office visits, specialist
none	Family planning services

* Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service
** The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE
	Outpatient Services
	Outpatient surgery
none	• Performed in office setting
none	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests
none	X-ray and diagnostic imaging
none	Imaging (CT/PET scans and MRIs)
none	Therapeutic injections, including allergy shots
	Hospitalization Services
none	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
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area
none	• Physician's office
none	• Urgent care center
none	• Emergency room — facility fees
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Walk-in pharmacy (30-day supply)
none	• Tier 1 - Preferred generic and certain preferred brand name medication
$30	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$50	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the deductible for a 30-day supply (access to Tier 4 medications at walk-in pharmacies is subject to limitations)
	Mail order (up to 90-day supply)
none	• Tier 1 - Preferred generic and certain preferred brand name medication
$75	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$125	• Tier 3 - Non-preferred medication[1]
20%*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the deductible for a 30-day supply, 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; refer to the Preferred Drug List (PDL).

Oral anti-cancer drugs will not exceed $200 after the deductible for a 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.

[1]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 after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE

Durable Medical Equipment (DME)

none	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
none	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

none	• Office visit
none	• Outpatient services
none	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
none	• Inpatient hospital services — provided at a residential treatment center
none	• 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

none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
none	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
none	Habilitation services
none	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • 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
none	Inpatient rehabilitation
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
none	• Acupuncture
none	• Chiropractic care, up to 20 visits per year

cost to member	ADDITIONAL HEALTH SERVICES — NOT SUBJECT TO DEDUCTIBLE
none	Pediatric vision examination, up to age 19
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, includes one of the following benefits: • One pair of glasses with standard lenses • One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, includes the following benefits: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

MANAGING YOUR HIGH-DEDUCTIBLE PLAN

The deductible and annual out-of-pocket maximum apply only to the covered services described in this Copayment Summary. Copayments and deductibles for any benefits purchased separately as a rider, including but not limited to infertility benefits, do not apply to this deductible or annual out-of-pocket maximum. 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 through 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.

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
$1,000*	Self-only coverage
$1,000*	Individual with Family coverage
$2,000*	Family coverage
	PRESCRIPTION (Rx) — Tiers 2 – 4
$250*	Self-only coverage
$250*	Individual with Family coverage
$500*	Family coverage

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.

$6,750	Self-only coverage
$6,750	Individual with Family coverage
$13,500	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

$40 per visit	Office visits, primary care and other practitioners not listed below
$40 per visit	Office visits, specialist
none	Adult vision examination
none	Pediatric vision examination, up to age 19
none	Hearing examination
$40 per visit	Family planning services

cost to member	Outpatient Services
	Outpatient surgery
$40 per visit	• Performed in office setting
$500 per visit, after deductible	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests
none	X-ray and diagnostic imaging
$250 per visit	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots
	Hospitalization Services
$500 per day, days 1-5, 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
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:
$40 per visit	• Physician's office
$50 per visit	• Urgent care center
$275 per visit, after deductible	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Walk-in pharmacy (30-day supply)
$10	• Tier 1 - Preferred generic and certain preferred brand name medication
$50, after Rx deductible	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$75, after Rx deductible	• Tier 3 - Non-preferred medication[1]
20%, after Rx deductible*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the Rx deductible per 30-day supply (access to Tier 4 medications at walk-in pharmacies is subject to limitations)
	Mail order (up to 90-day supply)
$25	• Tier 1 - Preferred generic and certain preferred brand name medication
$125, after Rx deductible	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$187.50, after Rx deductible	• Tier 3 - Non-preferred medication[1]
20%, after Rx deductible*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the Rx deductible per 30-day supply, 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; refer to the Preferred Drug List (PDL).

Oral anti-cancer drugs will not exceed $200 after the Rx deductible for a 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.

[1]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)
20%*	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
$40	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

$40 per visit	• Office visit
none	• Outpatient services
$500 per day, days 1-5, after deductible	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
$125 per day, days 1-5, after deductible	• Inpatient hospital services — provided at a residential treatment center
none	• 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

none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
$500 per day, days 1-5, 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
$40 per visit	Habilitation services
$40 per visit	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • 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
$500 per day, days 1-5, after deductible	Inpatient rehabilitation
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
$15 per visit	• Acupuncture
$15 per visit***	• Chiropractic care, up to 20 visits per year
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, including one of the following benefits: • One pair of glasses with standard lenses • One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, including the following benefits: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

* Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service.
** The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.
*** Copayments do not contribute to the medical 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 through 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.

Western Health Advantage

GATEWAY 6500 BRONZE 60 HDHP HMO

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
$6,500*	Self-only coverage
$6,500*	Individual with Family coverage
$13,000*	Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA is responsible for covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or Family coverage amount, whichever is met first. Once the deductible is met, the relevant copayment(s) will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services, as noted below. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

$6,500	Self-only coverage
$6,500	Individual with Family coverage
$13,000	Family coverage

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.

none	Lifetime maximum

cost to member	SERVICES NOT SUBJECT TO DEDUCTIBLE

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.

none	Adult vision examination
none	Hearing examination

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE

Professional Services

none	Office visits, primary care and other practitioners not listed below
none	Office visits, specialist
none	Family planning services

* Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service
** The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

GATEWAY 6500 BRONZE 60 HDHP HMO

cost to member after deductible is met

SERVICES SUBJECT TO DEDUCTIBLE

Outpatient surgery

none • Performed in office setting
none • Performed in facility — facility fees
none • Performed in facility — professional services
none Dialysis, infusion therapy and radiation therapy
none Laboratory tests
none X-ray and diagnostic imaging
none Imaging (CT/PET scans and MRIs)
none Therapeutic injections, including allergy shots

Hospitalization Services

none 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

none Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services

Urgent and Emergency Services

Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area

none • Physician's office
none • Urgent care center
none • Emergency room — facility fees
none • Emergency room — professional services
none • Ambulance service as medically necessary or in a life-threatening emergency (including 911)

Prescription Coverage

Walk-in pharmacy (30-day supply)

none • Tier 1 - Preferred generic and certain preferred brand name medication
none • Tier 2 - Preferred brand name or non-preferred generic medication[1]
none • Tier 3 - Non-preferred medication[1]
none • Tier 4 - Specialty medication when authorized in advance by WHA (access to Tier 4 medications at walk-in pharmacies is subject to limitations)

Mail order (up to 90-day supply)

none • Tier 1 - Preferred generic and certain preferred brand name medication
none • Tier 2 - Preferred brand name or non-preferred generic medication[1]
none • Tier 3 - Non-preferred medication[1]
none • 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; refer to the Preferred Drug List (PDL).

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.

[1]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 after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE

Durable Medical Equipment (DME)

none	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
none	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

none	• Office visit
none	• Outpatient services
none	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
none	• Inpatient hospital services — provided at a residential treatment center
none	• 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

none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
none	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
none	Habilitation services
none	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • 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
none	Inpatient rehabilitation

Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required

none	• Acupuncture
none	• Chiropractic care, up to 20 visits per year

cost to member	ADDITIONAL HEALTH SERVICES — NOT SUBJECT TO DEDUCTIBLE
none	Pediatric vision examination, up to age 19
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, includes one of the following benefits: • One pair of glasses with standard lenses • One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, includes the following benefits: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

MANAGING YOUR HIGH-DEDUCTIBLE PLAN

The deductible and annual out-of-pocket maximum apply only to the covered services described in this Copayment Summary. Copayments and deductibles for any benefits purchased separately as a rider, including but not limited to infertility benefits, do not apply to this deductible or annual out-of-pocket maximum. 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 through 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.

Western Health Advantage

DeltaCare® USA

PEDIATRIC DENTAL

ESSENTIAL HEALTH BENEFIT (EHB) | Services under the pediatric dental benefit are covered as described below for WHA members under 19 years of age. This is a combined benefit with your medical plan. See your WHA copayment summary.

DeltaCare USA[1] provides quality dental benefits at an affordable cost in this easy-to-use plan. The DeltaCare USA program encourages you to visit the dentist regularly to keep a healthy smile.

PLAN BENEFIT HIGHLIGHTS

- Posterior composites
- Additional cleanings
- Defined fees for metal upgrades
- Unlimited benefits[2]
- General anesthesia and IV sedation covered

CONVENIENT COPAYMENT SCHEDULE

While the benefits shown at right represent the most frequently used services covered under the plan, DeltaCare USA plans offer even more great features[3]. Plus, you don't have to worry about annual deductibles or benefit maximums for covered services—just pay the copayment. Copayments (where applicable) are paid to the DeltaCare USA dentist at the time of treatment.

FIND A PROVIDER

Upon enrollment, you'll choose a DeltaCare USA dentist from the nationwide network. You must visit your selected primary care dentist to receive benefits[2].

To locate a participating provider in your area:

visit deltadentalins.com
call 800.422.4234 (TTY/TDD 711)
Monday – Friday, 5 a.m. to 6 p.m.

DELTA DENTAL®

DeltaCare USA — PEDIATRIC BENEFITS[3]	Copayment
Diagnostic Services	
Periodic oral examinations	$0
X-rays	$0
Preventive Services	
Teeth cleaning (prophylaxis)	$0
Topical fluoride: child	$0
Restorative Services: Filling - Permanent	
Amalgam-three surfaces: primary or permanent	$40
Stainless steel crowns: primary teeth	$150
Oral Surgery Services	
Simple extraction of erupted tooth or exposed root	$65
Surgical extraction of erupted tooth	$135
Impaction: soft tissue	$135
Impaction: partial bony	$135
Impaction: full bony	$160
Endodontic Services	
Pulp cap: direct	$50
Root canal: anterior	$300
Root canal: bicuspid	$365
Root canal: molar	$300
Periodontic Services	
Gingivectomy: four or more contiguous teeth per quadrant	$150
Scaling/root planing: one to three teeth per quadrant	$75
Prosthodontic Services	
Crown: porcelain fused to predominantly base metal	$300
Post/core prefabrication	$100
Complete denture	$365
Partial denture	$365
Denture reline: chair side	$125
Orthodontia	
24 months of othodontic services	$875
Other Services	
Office visit: after hours	$0
Local anesthesia	$0

1 DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.
2 Services are covered only when performed by your selected primary care DeltaCare USA dentist, unless otherwise pre-authorized by Delta Dental of California.
3 This sample of copayments is only a summary of the plan coverage. Upon enrollment, the DeltaCare USA plan will make available a complete list of covered services and copayments, along with any limitations and exclusions that apply.

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. 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.

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 tinutulangan, 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.

Western Health Advantage

PEDIATRIC VISION

ESSENTIAL HEALTH BENEFIT (EHB)

Services and eyewear under the pediatric vision benefit are covered as described below for WHA members under 19 years of age. This is a combined benefit with your medical plan. See your WHA copayment summary.

FIND A PROVIDER: EYE EXAM

To schedule an eye exam, locate a participating provider in your area by searching WHA's online directory at mywha.org.com/directory.

EYE EXAMINATION BENEFITS

Examinations and fittings are covered under your medical plan with a WHA participating provider.

- One comprehensive eye examination per year is covered at no cost.
- Annual eye exams do not require a referral from your primary care physician (PCP), but members must select a WHA participating provider.
- Other than the annual eye exam, all vision exams require a referral from your PCP.

FIND A PROVIDER: EYEWEAR

As described, most glasses and contact lenses benefits and low vision devices are provided by MES. To obtain glasses, contacts or low vision devices through MES under the pediatric vision benefit, you *must obtain* your eyewear from an MES participating provider. It is your responsibility to identify yourself or the member as having an MES plan.

MES Vision®

Customer Service Department

Monday – Friday
8 a.m. to 5 p.m.
call 800.877.6372
visit mesvision.com

EYEWEAR BENEFITS

Glasses, lenses, elective contact lenses and low vision devices are generally covered through MESVision, except as specifically noted below.

- The following are covered by MES at no cost:
  - One pair of glasses with standard lenses; or
  - One pair of standard hard or six pairs of standard soft contact lenses per calendar year instead of glasses
  - One pair of medically necessary contact lenses (except as noted below).

If your WHA participating provider has determined you need contact lenses, they will be covered by MES or by WHA, as listed below:

- Medically necessary contact lenses require prior authorization and are covered by MES for the following conditions: Keratoconus (visual acuity to 20/40), Pathological Myopia, Hyperopia, Anisometropia (visual acuity to 20/60), Corneal Disorders, and Irregular Astigmatism.
- Medically necessary contact lenses require prior authorization and are covered by WHA for the following conditions: Aniseikonia, Aniridia, Post-traumatic Disorders, including Avoidance of Diplopia or Suppression, and Aphakia. To obtain medically necessary contact lenses through WHA, you must obtain a referral from your PCP.
- Expanded benefit for Aniridia and Aphakia: Two medically necessary contact lenses per eye are covered in any 12-month period to treat Aniridia. Six medically necessary contact lenses per eye are covered per calendar year to treat Aphakia including fitting and dispensing, for members through nine years of age.
- For children with low vision (defined as a significant loss of vision but not total blindness), one pair of high-power spectacles per calendar year and a lifetime maximum of one magnifier and one telescope are covered at no charge, with prior authorization.

Western Health Advantage

CAM BENEFITS

CHIROPRACTIC AND ACUPUNCTURE COVERAGE

Complementary and Alternative Medicine (CAM) is covered as part of your plan from WHA. This benefit allows medically necessary acupuncture and chiropractic care provided through Landmark Healthplan of California, Inc.

As part of your medical plan for WHA:

- PCP referral is not required to receive covered services
- Acupuncture — as medically necessary
- Chiropractic care — up to 20 medically necessary visits per year

See your medical copayment summary to verify your coverage and to determine the cost of acupuncture or chiropractic care.

ACUPUNCTURE BENEFIT: Covers treatment of pain related to acute neuromusculoskeletal conditions such as dysfunction of the neck, back or joints, headaches, carpal tunnel, arthritis, allergies and asthma. Acupuncture services must be authorized. Typically covered acupuncture services include:

- Evaluation
- Manual stimulation
- Electroacupuncture
- Moxibustion
- Acupressure
- Cupping

CHIROPRACTIC BENEFIT: Covers treatment of pain related to acute neuromusculoskeletal conditions such as low back pain, sprains and strains, headaches, neck pain and muscle spasms. Chiropractic services must be authorized. Typically covered chiropractic services include:

- History
- Conjunctive physiotherapy
- Examination
- X-rays
- Manipulation

Note: This information is a summary of the highlights about your acupuncture and chiropractic coverage. For complete benefit information, refer to your Combined Evidence of Coverage and Disclosure Form and Schedule of Benefits for Landmark Healthplan of California, Inc. on the WHA website at mywha.org.

FIND A PROVIDER

LANDMARK HEALTHPLAN OF CALIFORNIA, INC.
Member Services Department
call 800.298.4875 | visit www.lhp-ca.com

Call Landmark Healthplan or visit their website to locate a participating practitioner in your area.

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

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 at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

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, ancestry, religion, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation age, or disability, you can file a grievance by telephone, mail, fax, email, or online 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, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, 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.

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 tinutulangan, 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.