Western Health Advantage

PREMIER 15

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.

cost to member	
	DEDUCTIBLE
none	Deductible amount
	ANNUAL OUT-OF-POCKET MAXIMUM
	The maximum out-of-pocket expense for a member per calendar year is limited to either the Self-only, Individual with Family or Family coverage amount, whichever is met first:
$1,500	Self-only coverage
$1,500	Individual with Family coverage
$2,500	Family coverage
none	Lifetime maximum
	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
$15 per visit	Office visits, primary care physician (PCP)
$15 per visit	Office visits, specialist
$15 per visit**	Vision and hearing examinations
$15 per visit	Family planning services
	Outpatient Services
	Outpatient surgery
$15 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, X-ray and diagnostic imaging
none	Imaging (CT/PET scans and MRIs)
$5 per visit	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

cost to member	
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:
$15 per visit	• Physician's office
$20 per visit	• Urgent care center
$100 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
	Outpatient prescription medications are excluded, unless the Employer has selected an optional prescription rider plan (see your Prescription Copayment Summary, if applicable).
	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
$15	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
$15 per visit	• Office visit
none	• Outpatient services
none	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
none	• Inpatient hospital services — provided at 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 calendar year
none	Hospice services
$15 per visit	Habilitation services
$15 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
none	Inpatient rehabilitation
20%*	Home self-injectable medication, up to $100 maximum copay per 30-day supply, limited to a 30-day supply; insulin is covered under the prescription benefit
	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, up to 20 visits per year
$15 per visit**	• Chiropractic care, up to 20 visits per year

* Percentage copayments are based upon WHA's contracted rates with the provider of service.
** Copayments do not contribute to the medical out-of-pocket maximum.