Western 2800MHP: An HSA-Compatible Plan

COPAYMENT SUMMARY — *A uniform health plan benefit and coverage matrix*

Western Health Advantage

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	MEMBER RESPONSIBILITY *(OUT-OF-POCKET COSTS)*
ANNUAL DEDUCTIBLE	
Amount if enrolled as Single Member only	$2,800
Amount if enrolled as Family	$5,600

The *annual deductible* is the amount of money a member or family must pay for covered services before WHA will cover those services. After the deductible is met the applicable copayments will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services as noted below. The deductible is applied each calendar year. If you have family coverage, there is no single deductible for each family member; rather, the entire Family deductible must be met before WHA becomes responsible for providing covered services for any individual member in the family. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM	
Amount if enrolled as Single Member only	$4,000
Amount if enrolled as Family	$8,000

The *out-of-pocket maximum* is the maximum total amount of copayments and deductibles that a member or the family must pay for covered services during any calendar year. If you have family coverage, there is no single out-of-pocket maximum for each family member; rather, the entire Family out-of-pocket maximum must be met before you do not have to pay any more copayments for that calendar year. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

Lifetime maximum	None

	COST TO MEMBER
PREVENTIVE CARE SERVICES (*NOT* SUBJECT TO DEDUCTIBLE)	
Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF	None
Annual physical examinations and well baby care	None
Immunizations, adult and pediatric	None
Women's preventive services	None
Maternity care, after the initial diagnosis, pre and post-natal visits and laboratory tests	None
Breast, cervical, prostate and colorectal cancer screenings	None
Eye and hearing examinations	$40 per visit

Note: procedures resulting from screenings are not considered preventative 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.

	COST TO MEMBER *AFTER DEDUCTIBLE IS MET*
PROFESSIONAL SERVICES (SUBJECT TO DEDUCTIBLE)	
Office visits, primary care physician or specialist	$40 per visit
Family planning services	$40 per visit

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	COST TO MEMBER *AFTER DEDUCTIBLE IS MET*
OUTPATIENT SERVICES (SUBJECT TO DEDUCTIBLE)	
Outpatient surgery (performed in office setting)	$40 per visit
Outpatient surgery (facility)	
• Facility fees	$250 per visit
• Professional services	None
Laboratory, X-ray, electrocardiograms and all other tests.	None
Therapeutic injections, including allergy shots	$5 per visit
Other generally accepted cancer screening tests	None
HOSPITALIZATION SERVICES (SUBJECT TO DEDUCTIBLE)	
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:	$500 per day
• 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	
Professional inpatient services, including:.	None
• Physicians' services, including surgeons, anesthesiologists and consultants	
• Private-duty nurse when prescribed by a participating physician	
URGENT AND EMERGENCY SERVICES (SUBJECT TO DEDUCTIBLE)	
Outpatient care to treat an injury or the sudden onset of an acute illness within or outside the WHA Service Area:	
Physician's office.	$40 per visit
Urgent care center.	$50 per visit
Hospital emergency room, waived if admitted	$100 per visit
Ambulance service as medically necessary or in a life-threatening emergency, including 911	None
PRESCRIPTION COPAYMENTS FOR COVERED MEDICATIONS (SUBJECT TO DEDUCTIBLE)	
Walk-In Pharmacy, up to 30-day supply	
• Tier 1 – Preferred Generic medication	$10
• Tier 2 – Preferred Brand Name medication	$30
• Tier 3 – Non-Preferred medication	$50
Mail Order, up to 90-day supply	
• Tier 1 – Preferred Generic medication	$25
• Tier 2 – Preferred Brand Name medication	$75
• Tier 3 – Non-Preferred medication	$125
The following prescription medications are covered at no cost to the member (generic required if available): prenatal vitamins, folic acid, fluoride for preschool age children, tobacco cessation medication and women's contraceptives.	
DURABLE MEDICAL EQUIPMENT (DME) (SUBJECT TO DEDUCTIBLE)	
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% copay
Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA	$40

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COST TO MEMBER
AFTER DEDUCTIBLE IS MET

BEHAVIORAL HEALTH SERVICES (SUBJECT TO DEDUCTIBLE)

Outpatient services for mental health disorders and substance abuse . . . . . $40 per visit

Inpatient hospital services for the treatment of mental health disorders, provided at a:

Participating acute care facility . . . . . $500 per day

Residential treatment center or partial hospitalization. . . . . $125 per day

Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).

Inpatient hospital services for substance abuse, including detoxification, provided at a:

Participating acute care facility . . . . . $500 per day

Residential treatment center or partial hospitalization. . . . . $125 per day

OTHER HEALTH SERVICES (SUBJECT TO DEDUCTIBLE)

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. . . . . $500 per day

Outpatient rehabilitative services, including: . . . . . $40 per visit

- Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary
- Respiratory therapy, cardiac rehabilitation and pulmonary rehabilitation, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement

Inpatient rehabilitation. . . . . $500 per day

Home self injectables, up to $100 maximum copay per 30-day supply (self injectable specialty medications that cost over $500 for a 30-day supply are limited to a 30-day supply; insulin is covered under the prescription benefit) . . . . . 20% copay

ADDITIONAL INFORMATION

COPAYMENTS AND DEDUCTIBLES

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

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 your copayments and deductible payments for the services described in this Copayment Summary have reached the annual out-of-pocket maximum, WHA will automatically provide you a document to show that you do not have to pay any more copayments or deductibles for covered services through the end of the calendar year.

To view the amounts applied to your annual deductible and out-of-pocket maximum, simply access your accumulator through Personal Access at westernhealth.com.

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.

CONTACT US

If you have any questions, please call WHA Member Services between 8 a.m. and 5 p.m., Monday through Friday, at 916.563.2250 or toll free at 888.563.2250.

Important: Health Savings Accounts (HSAs) are complex financial products. WHA recommends that you consult your tax or financial advisor to determine whether HSAs and this high-deductible health care plan are a good choice for you.