



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.

DEDUCTIBLE **COST TO MEMBER**
 Medical None

In any calendar year we will not cover certain medications until the member meets the following deductible:

Prescription (for Preferred brand name and Non-Preferred medications) None

ANNUAL OUT-OF-POCKET MAXIMUM **COST TO MEMBER**

The maximum out-of-pocket expense for a Member per calendar year is limited to either the Individual amount or Family amount, whichever is met first:

Individual \$2,000

Family \$4,000

All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.

Lifetime maximum None

PREVENTIVE CARE SERVICES **COST TO MEMBER**

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

Maternity care, after the initial diagnosis, pre and post-natal visits and laboratory tests None

Breast, cervical, prostate and colorectal cancer screenings None

Note: procedures resulting from screenings are not considered preventive care.

PROFESSIONAL SERVICES **COST TO MEMBER**

Office visits, primary care physician or specialist \$15 per visit

Eye and hearing examinations \$15 per visit

Family planning services \$15 per visit

OUTPATIENT SERVICES **COST TO MEMBER**

Outpatient surgery (performed in office setting) \$15 per visit

Outpatient surgery (facility) \$200 per visit

Outpatient surgery (Ambulatory Surgical Center — ASC) \$100 per visit

Laboratory, X-ray, electrocardiograms and all other tests \$15 per visit

MRI, CT and PET scans None

Therapeutic injections, including allergy shots \$5 per visit

Other generally accepted cancer screening tests None

HOSPITALIZATION SERVICES **COST TO MEMBER**

Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: \$400 per admission

- 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	COST TO MEMBER
Outpatient care to treat an injury or the sudden onset of an acute illness within or outside the WHA Service Area:	
Physician's office.....	\$15 per visit
Urgent care center.....	\$15 per visit
Hospital emergency room (waived if admitted).....	\$100 per visit
Ambulance service as medically necessary or in a life-threatening emergency (including 911).....	\$50 per trip
 PRESCRIPTION COVERAGE	 COST TO MEMBER
Walk-In Pharmacy (30 day supply)	
Preferred generic / Preferred brand name / Non-Preferred medication.....	\$10/\$20/\$35*
Mail Order (90 day supply)	
Preferred generic/ Preferred brand name/ Non-Preferred medication.....	\$25/\$50/\$87.50*
Infertility drugs (limited to a \$1,500 lifetime maximum).....	50% of allowed charges*
The following prescription medications are covered at no cost to the member (generic only): prenatal vitamins, folic acid, fluoride for preschool age children and tobacco cessation medication.	
 DURABLE MEDICAL EQUIPMENT (DME)	 COST TO MEMBER
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.....	
	10% to annual maximum of \$2,500*
Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA.....	
	\$15
 BEHAVIORAL HEALTH SERVICES	 COST TO MEMBER
Outpatient services for mental health disorders and substance abuse.....	
	\$15 per visit
Inpatient hospital services for the treatment of mental health disorders, provided at a:	
Participating acute care facility.....	\$400 per admission
Residential treatment center or partial hospitalization.....	\$125 per admission
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 detoxification only, provided at a participating acute care facility.....	
	\$400 per admission
Substance abuse rehabilitation is not covered on an outpatient or inpatient basis.	
 OTHER HEALTH SERVICES	 COST TO MEMBER
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.....	
	\$400 per disability
Outpatient rehabilitative services, including:	
• Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary	
• Short-term 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.....	\$400 per admission
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*
Infertility evaluation and treatment (except in vitro fertilization).....	50% of allowed charges*

* Copayments and the prescription deductible do not contribute to the out-of-pocket maximum (unless required for the management or treatment of diabetes or pediatric asthma supplies and equipment). Percentage copayment amounts are based on WHA's contracted rate.