



**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.**

<b>DEDUCTIBLE</b>	<b>COST TO MEMBER</b>
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) . . . . .	\$200 per member*

<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>	<b>COST TO MEMBER</b>
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 . . . . .	\$3,500
Family . . . . .	\$7,000
All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.	
Lifetime maximum . . . . .	None

<b>PREVENTIVE CARE SERVICES</b>	<b>COST TO MEMBER</b>
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.	

<b>PROFESSIONAL SERVICES</b>	<b>COST TO MEMBER</b>
Office visits, primary care physician or specialist . . . . .	\$40 per visit <sup>+</sup>
Eye and hearing examinations . . . . .	\$40 per visit <sup>+</sup>
Family planning services. . . . .	\$40 per visit <sup>+</sup>

<b>OUTPATIENT SERVICES</b>	<b>COST TO MEMBER</b>
Outpatient surgery (performed in office setting) . . . . .	\$40 per visit <sup>+</sup>
Outpatient surgery (facility) . . . . .	\$500 per visit <sup>+</sup>
Outpatient surgery (Ambulatory Surgical Center — ASC) . . . . .	\$250 per visit <sup>+</sup>
Laboratory, X-ray, electrocardiograms and all other tests. . . . .	\$40 per visit
MRI, CT and PET scans . . . . .	\$50 per visit <sup>+</sup>
Therapeutic injections, including allergy shots . . . . .	\$5 per visit
Other generally accepted cancer screening tests . . . . .	None

<b>HOSPITALIZATION SERVICES</b>	<b>COST TO MEMBER</b>
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: . . . . .	\$500 per day <sup>+</sup>
<ul style="list-style-type: none"> <li>• Newborn delivery (private room when determined medically necessary by a participating provider)</li> <li>• 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</li> </ul>	
Professional inpatient services, including: . . . . .	None
<ul style="list-style-type: none"> <li>• Physicians' services, including surgeons, anesthesiologists and consultants</li> <li>• Private-duty nurse when prescribed by a participating physician</li> </ul>	

# CalChoice 40B

COPAYMENT SUMMARY — A uniform health plan benefit and coverage matrix



<b>URGENT AND EMERGENCY SERVICES</b>	<b>COST TO MEMBER</b>
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 <sup>+</sup>
Urgent care center . . . . .	\$40 per visit <sup>+</sup>
Hospital emergency room (waived if admitted) . . . . .	\$250 per visit <sup>+</sup>
Ambulance service as medically necessary or in a life-threatening emergency (including 911) . . . . .	\$200 per trip <sup>+</sup>
<b>PRESCRIPTION COVERAGE</b>	<b>COST TO MEMBER</b>
Walk-In Pharmacy (30 day supply)	
Preferred generic / Preferred brand name / Non-Preferred medication . . . . .	\$20/\$30/\$50**
Mail Order (90 day supply)	
Preferred generic/ Preferred brand name/ Non-Preferred medication . . . . .	\$50/\$75/\$125**
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.	
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	<b>COST TO MEMBER</b>
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 . . . . .	
	50% 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 . . . . .	
	\$40 <sup>+</sup>
<b>BEHAVIORAL HEALTH SERVICES</b>	<b>COST TO MEMBER</b>
Outpatient services for mental health disorders and substance abuse . . . . .	
	\$40 per visit <sup>+</sup>
Inpatient hospital services for the treatment of mental health disorders, provided at a:	
Participating acute care facility . . . . .	\$500 per day <sup>+</sup>
Residential treatment center or partial hospitalization . . . . .	\$125 per day <sup>+</sup>
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 . . . . .	
	\$500 per day <sup>+</sup>
Substance abuse rehabilitation is not covered on an outpatient or inpatient basis.	
<b>OTHER HEALTH SERVICES</b>	<b>COST TO MEMBER</b>
Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year . . . . .	
	\$50 per visit <sup>+</sup>
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 <sup>+</sup>
Outpatient rehabilitative services, including: . . . . .	
	\$40 per visit <sup>+</sup>
• 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 . . . . .	\$500 per day <sup>+</sup>
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*

<sup>+</sup> Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less. Copayments will never exceed the amounts or percentage ratios set forth above.

\* 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.