CalChoice 40VMHP

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 AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLE	COST TO MEMBER
In any calendar year we will not cover certain services until the following deductible is met. The deductible for a member is limited to either the Individual amount or Family amount, whichever is met first:	
Medical (including inpatient and emergency services)	$2,500 Individual $5,000 Family
Prescription (for Preferred brand name and Non-Preferred brand name medications)	$250 per member*

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	$5,000
Family	$10,000
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	$40 per visit
Eye and hearing examinations	$40 per visit
Family planning services	$40 per visit

OUTPATIENT SERVICES	COST TO MEMBER
Outpatient surgery (performed in office setting)	$40 per visit
Outpatient surgery (facility)	$250 per visit
Outpatient surgery (Ambulatory Surgical Center — ASC)	$250 per visit
Laboratory, X-ray, electrocardiograms and all other tests	None
MRI, CT and PET scans	$50 per visit
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: • 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	$500 per day after deductible‡
Professional inpatient services, including: • Physicians' services, including surgeons, anesthesiologists and consultants • Private-duty nurse when prescribed by a participating physician	None

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	$40 per visit
Urgent care center	$50 per visit

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URGENT AND EMERGENCY SERVICES (CONTINUED)	**COST TO MEMBER**
Hospital emergency room (waived if admitted)	$250 per visit after deductible‡
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 medication	$20*
• Preferred brand name medication	$30 after deductible‡*
• Non-Preferred generic medication	$50*
• Non-Preferred brand name medication	$50 after deductible‡*
Mail Order (90 day supply)	
• Preferred generic medication	$50*
• Preferred brand name medication	$75 after deductible‡*
• Non-Preferred generic medication	$125*
• Non-Preferred brand name medication	$125 after deductible‡*
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	20% 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

BEHAVIORAL HEALTH SERVICES	**COST TO MEMBER**
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 after deductible‡
Residential treatment center or partial hospitalization	$125 per day after deductible‡
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 after deductible‡
Residential treatment center or partial hospitalization	$125 per day after deductible‡

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	$500 per day after deductible‡
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	
• 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 after deductible‡
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*

‡ These services are subject to a deductible. You must pay for these services when you receive them, until you or your family meet the deductible amounts shown above. Charges under the deductible are based on WHA's contracted rates with the Provider of Service.

* 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.