

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

DEDUCTIBLE **COST TO MEMBER**
Deductible amount 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 \$1,500
Family \$2,500

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

Lifetime maximum None

PROFESSIONAL SERVICES **COST TO MEMBER**

Office visits for adult and pediatric care \$15 per visit

Well-baby care, birth up to two years None

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

Immunizations, adult and pediatric None

Periodic physical examinations \$15 per visit

Office visits for consultation or care by a non-primary provider when referred by your primary care physician \$15 per visit

Allergy testing \$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) \$100 per visit

Laboratory, X-ray, electrocardiograms and all other tests None

Therapeutic injections, including allergy shots \$5 per visit

All 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: None

- 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 and nursery care for newborn babies
- Blood transfusion services
- Rehabilitative services

Professional inpatient services, including: None

- Physicians' services, including surgeons, anesthesiologists and consultants
- Private-duty nurse when prescribed by a participating physician

Premier 15

COPAYMENT SUMMARY — A uniform health plan benefit and coverage matrix



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 | \$20 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 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)

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% copay* |
| 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 | None |
| Residential treatment center or partial hospitalization | None |
| 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 | None |
| Substance abuse rehabilitation is not covered on an outpatient or inpatient basis. | |

HOME 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 |
|---|------|

OTHER HEALTH SERVICES

COST TO MEMBER

| | |
|---|----------------|
| 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 |
| Outpatient rehabilitative services, including: | \$15 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 | None |
| 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* |
| Chiropractic and Acupuncture benefits are provided through Landmark Healthplan of California, Inc., a California Knox Keene licensed plan (see additional benefit information).* | |

* Copayments 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.