Western 2800BMHP: An HSA Compatible Plan

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.

	MEMBER RESPONSIBILITY *(OUT-OF-POCKET COSTS)*
ANNUAL DEDUCTIBLE	
Amount for Individual or	$2,800
Amount for 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. Each family member in the Family unit must meet the Individual amount before WHA becomes responsible for providing covered services for that individual in the family, unless the family meets the Family amount first. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM	
Amount for Individual or	$4,000
Amount for 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. Each family member in the Family unit must meet the Individual amount before you do not have to pay any more copayments or deductibles for that calendar year, unless the family meets the Family amount first. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

Lifetime maximum	None

PREVENTIVE CARE SERVICES (*NOT* SUBJECT TO DEDUCTIBLE)	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.	
Eye and hearing examinations	$40 per visit

	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
OUTPATIENT SERVICES (SUBJECT TO DEDUCTIBLE)	
Outpatient surgery (performed in office setting)	$40 per visit
Outpatient surgery (facility)	$250 per visit
Laboratory, X-ray, electrocardiograms and all other tests	None
Therapeutic injections, including allergy shots	$5 per visit
Other generally accepted cancer screening tests	None

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	COST TO MEMBER *AFTER DEDUCTIBLE IS MET*
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
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
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

	COST TO MEMBER *AFTER DEDUCTIBLE IS MET*
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	
• 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
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

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 with 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.

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.

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

To see how much you have paid toward your annual deductible, log onto WHA's website at westernhealth.com. Log in with your Personal Access ID. If you do not have a Personal Access ID, sign up for it on the website and a PIN number will be emailed to you. For your annual deductible balance, follow the "Eligibility Information" link. Click on "Deductible Balances" to see how much has been applied toward your annual deductible during the calendar year.

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 at (916) 563-2250 or toll free at (888) 563-2250.

PRESCRIPTION COVERAGE

WHA shall cover Prescription medications at Participating Pharmacies and prescribed in connection with a covered service.

Regardless of medical necessity or generic availability, you will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and you elect to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, you will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment.

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.

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the member will only be responsible for paying the actual cost of the medication.

COVERED PRESCRIPTION MEDICATIONS

- Oral medications that require a Prescription by state or federal law, written by a Participating Physician and dispensed by a Participating Pharmacy.
- Covered Prescription medications dispensed by a non-Participating Pharmacy outside of WHA's service area for urgent or emergency care only (you may submit your receipt to WHA for reimbursement).
- Compounded Prescriptions that contain at least one Prescription ingredient and have no FDA-approved alternative.
- Insulin, insulin syringes with needles, glucose test strips and tablets.
- Oral contraceptives and diaphragms.
- Pediatric asthma supplies and devices.

PRESCRIPTION DEFINITIONS

Preferred Drug List (PDL) is a preferred listing of medications developed by WHA's Pharmacy and Therapeutics (P&T) Committee as drugs of choice in their respective classes of Preferred generic medication or Preferred brand name medication. Please note that a drug's presence on the WHA PDL does not guarantee that the member's physician will prescribe the drug. Members may request a copy of the PDL by calling WHA Member Services or view the document on WHA's website at westernhealth.com.

Three-tier Copay Plan means Preferred generic medications listed on the PDL are covered at the lowest tier copayment level, brand name medications listed on the PDL are provided at the second tier copayment level, and drugs not listed on the PDL (generic or brand name) are covered at the third tier copayment level. There are a small number of drugs, regardless of tier, that may require prior authorization to ensure the appropriate use based on criteria set by the WHA P&T Committee.

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.