

# Hospital Services DHMO

**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/DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

**cost to member DEDUCTIBLE**

The medical and prescription deductibles are the amount of money a member or family must pay for certain covered services before WHA is responsible for those covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or the Family coverage amount, whichever is met first.

**MEDICAL (including inpatient, outpatient surgery and emergency services)**

- \$1,500\* Self-only coverage
- \$1,500\* Individual with Family coverage
- \$3,000\* Family coverage

**ANNUAL OUT-OF-POCKET MAXIMUM**

The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. It includes the deductible and copayments. Once the deductible and copayment costs reach the annual out-of-pocket maximum, WHA will cover 100% of the covered services for the remainder of the calendar year. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

- \$4,000 Self-only coverage
- \$4,000 Individual with Family coverage
- \$8,000 Family coverage
- none Lifetime maximum

**Preventive Care Services**

none Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF

- Annual physical examinations and well baby care
- Immunizations, adult and pediatric
- Women's preventive services
- Routine prenatal care and lab tests, and first post-natal visit
- Breast, cervical, prostate, colorectal and other generally accepted cancer screenings

Note: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered "preventive," the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in this copayment summary.

**Professional Services**

- \$20 per visit Office visits, primary care physician (PCP)
- \$20 per visit Office visits, specialist
- none Vision and hearing examinations
- \$20 per visit Family planning services



**cost to member Outpatient Services**

- \$20 per visit • Outpatient surgery
- 20% after deductible\* • Performed in office setting
- 20% after deductible\* • Performed in facility — facility fees
- none • Performed in facility — professional services
- none Dialysis, infusion therapy and radiation therapy
- none Laboratory tests, X-ray and diagnostic imaging
- none Imaging (CT/PET scans and MRIs)
- none Therapeutic injections, including allergy shots

**Hospitalization Services**

- 20% after deductible\* 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
- 20% after deductible\* Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services

**Urgent and Emergency Services**

- Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:
  - \$20 per visit • Physician’s office
  - \$20 per visit • Urgent care center
  - 20% after deductible\* • Emergency room — facility fees (waived if admitted)
  - 20% after deductible\* • Emergency room — professional services
  - \$150 per trip • Ambulance service as medically necessary or in a life-threatening emergency (including 911)

**Prescription Coverage**

See Prescription H2 Copayment Summary for additional information

Walk-in pharmacy (30-day supply)

- \$10 • Tier 1 - Preferred generic medication
- \$30 • Tier 2 - Preferred brand name medication<sup>1</sup>
- \$50 • Tier 3 - Non-preferred medication<sup>1</sup>

Mail order (up to 90-day supply)

- \$20 • Tier 1 - Preferred generic medication
- \$60 • Tier 2 - Preferred brand name medication<sup>1</sup>
- \$100 • Tier 3 - Non-preferred medication<sup>1</sup>

Access to specialty medications at walk-in pharmacies is subject to limitations.

The following prescription medications are covered at no cost to the member (generic required if available): aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication and women’s contraceptives.

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.

<sup>1</sup>Regardless of medical necessity or generic availability, the member 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 the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment.\*\*\*

**Durable Medical Equipment (DME)**

- 20%\* 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 Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA

**cost to member Behavioral Health Services**

	Mental Health Disorders and Substance Abuse
\$20 per visit	• Office visit
none	• Outpatient services
20% after deductible*	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
20% after deductible*	• Inpatient hospital services — provided at residential treatment center
20% after deductible*	• Inpatient professional services, including physician services

Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).

**Other Health Services**

none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
20% after deductible*	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 benefit period
none	Hospice services
\$20 per visit	Habilitation services
\$20 per visit	Outpatient rehabilitative services, including: <ul style="list-style-type: none"> <li>• Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary</li> <li>• Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement</li> </ul>
20% after deductible*	Inpatient rehabilitation
none	Home self-injectable medication, limited to a 30-day supply; insulin is covered under the prescription benefit
	Infertility services — covered under the Infertility A rider plan (see Infertility Copayment Summary)**
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
\$15 per visit	• Acupuncture, up to 20 visits per year
\$15 per visit**	• Chiropractic care, up to 20 visits per year

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

\*\* Copayments do not contribute to the medical out-of-pocket maximum.

\*\*\* The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

**MANAGING YOUR HIGH-DEDUCTIBLE PLAN**

When you reach your annual out-of-pocket maximum described in this Copayment Summary, WHA will mail you a letter to inform you that you do not have to pay any more copayments or deductibles for covered services through the end of the calendar year. To review amounts applied to your annual deductible and out-of-pocket maximum, simply access your accumulator through [mywha.org](http://mywha.org). 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.