westernhealth ADVANTAGE

a Medicare coordinated plan

# Dignity Health PLAN 211A HMO PRIME

**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.**

## ANNUAL DEDUCTIBLE

| member responsibility | Medical Deductible |
|---|---|
| none | Deductible amount |

## 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.

| member responsibility | Out-of-Pocket Maximum |
|---|---|
| $1,000 | Self-only coverage |
| $1,000 | Individual with Family coverage |
| $2,500 | Family coverage |
| none | Lifetime maximum |

## COVERED WITHOUT COST-SHARING

**Preventive care services and some prescription medications (generic required) are covered at no cost to the member,** as outlined under EOC/DF section Preventive Services Covered without Cost-Sharing. See additional benefit information at mywha.org/preventive.

- 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
- Family planning, including FDA-approved contraception and sterilization procedures; counseling, education
- Aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication, contraceptives

NOTE: In order for a service to be considered "preventive," the service must be provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must be to obtain the preventive service. In the event you receive additional services that are not part of the preventive exam (for example, procedures or labs resulting from screenings or in response to your medical condition or symptoms), you will be responsible for the cost of those services as described in this copayment summary.

## COVERED WITH COST-SHARING

| cost to member | Percentage copayments are based on WHA's contracted rates with the provider of service |
|---|---|

### Professional Services

| | |
|---|---|
| $10 per visit | Office or virtual visits, primary care and other practitioners not listed below |
| $10 per visit | Office or virtual visits, specialist |
| $10 per visit | Vision and hearing examinations; with the exception of pediatric vision exams, copayments for these services do not contribute to the medical out-of-pocket maximum |

### Outpatient Services

| | |
|---|---|
| | Outpatient surgery |
| $10 per visit | • Performed in office setting |
| none | • Performed in facility — facility fees |
| none | • Performed in facility — professional services |
| none | Dialysis, chemotherapy, infusion therapy and radiation therapy |
| none | Laboratory tests |
| none | X-ray and diagnostic imaging |
| none | Imaging (CT/PET scans and MRIs) |
| $5 per visit | Therapeutic injections, including allergy shots |

### Hospitalization Services

| | |
|---|---|
| none | Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:<br>• Newborn delivery (private room when determined medically necessary by a participating provider)<br>• 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 |
| none | 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: |
| $10 per visit | • Physician's office or virtual visit |
| $15 per visit | • Urgent care virtual visit |
| $20 per visit | • Urgent care center |
| $50 per visit | • Emergency room — facility fees (waived if admitted) |
| none | • Emergency room — professional services |
| none | • Ambulance service as medically necessary or in a life-threatening emergency (including 911) |

### Prescription Coverage

| | |
|---|---|
| see Rx Copayment Summary | Outpatient prescription medications are covered under the prescription rider plan |

### Durable Medical Equipment (DME)

| | |
|---|---|
| 20% | Durable medical equipment when determined by a participating physician to be medically necessary and when authorized in advance by WHA |
| $10 | Orthotic and prosthetic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA |

### Behavioral Health Services

| | |
|---|---|
| | Mental Health Disorders and Substance Use Disorders |
| $10 per visit | • Office or virtual visit |
| none | • Outpatient other services |
| none | • Inpatient hospital services, including detoxification — provided at a participating acute care facility |
| none | • Inpatient hospital services — provided at residential treatment center |
| none | • Inpatient professional services, including physician services |

## COVERED WITH COST-SHARING

| cost to member | Percentage copayments are based on WHA's contracted rates with the provider of service |
|---|---|

### 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 |
| 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 |
| none | Hospice Services |
| $10 per visit | Habilitation services |
| $10 per visit | Outpatient rehabilitative services, including:<br>• Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary<br>• 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 |
| none | Inpatient rehabilitation |
| none | Abortion and abortion-related services |
| 50% | Infertility testing, copayments for these services do not contribute to the medical out-of-pocket maximum |
| see Infertility A Copayment Summary | Infertility services covered under Infertility rider, copayments for these services do not contribute to the medical out-of-pocket maximum |
| $15 per visit | Acupuncture and chiropractic services are provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at mywha.org.<br>• Acupuncture, up to 20 visits per year<br>• Chiropractic care, up to 20 visits per year; copayments do not contribute to the medical out-of-pocket maximum |