



Western Health Advantage 2008 Benefit Comparison

	Premier 20 Rxe	Advantage 40 Rxe
Outpatient Services		
Physician's Office Visits	\$20 per visit	\$40 per visit
Well Baby Care (0 - 2 yrs)	Covered in full	Covered in full
Outpatient Surgery (Facility)	\$100 per visit	30% Copay
Outpatient Surgery (Office)	\$20 per visit	\$40 per visit
X-ray, lab & other tests	No Charge	No Charge
Allergy Testing	\$20 per visit	\$40 per visit
Periodic Physical Exams	\$20 per visit	\$40 per visit
Immunizations - Adult and Pediatric	No Charge	No Charge
Eye and Hearing Exams (all ages)	\$20 per visit	\$40 per visit
Inpatient Hospitalization		
Hospital Inpatient Services & Supplies	No Charge	30% Copay
Skilled Nursing Care/Mental Health/Chemical Dependency	No Charge	30% Copay
Inpatient - Mental Health	Covered in full - To 20 days per calendar year	30% Copay - Up to 20 days per calendar year
Outpatient - Mental Health	\$20 per visit - 20 visits in a calendar year*	\$40 per visit - up to 20 days per calendar year*
Inpatient Alcohol/Drug Care	No Charge - Detox Only	30% Copay
Outpatient Alcohol/Drug Care	\$20 per visit - 20 visits per calendar year*	\$40 per visit - up to 20 days per calendar year*
Severe Mental Illness		
Outpatient Visits	\$20 per visit	\$40 per visit
Inpatient Hospitalization	Covered at 100%	30% Copay
Urgent/Emergency Care		
Physicians Office	\$20 per visit	\$40 per visit
Emergency Room	\$100 per visit	\$100 per visit
Urgent Care Center	\$35 per visit	\$50 per visit
Maximum Out-of-Pocket Expense	\$1500 per Individual \$2500 per family	\$3000 per Individual \$5000 per family
Prescriptions		
	Rxe	Rxe
Generic	\$10	\$10
Brand Name	\$20	\$30
Non-Preferred Brand Name	\$30	\$50

*Combined Benefit

Premier 20

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 **YOU PAY**
Deductible amount None

ANNUAL OUT-OF-POCKET MAXIMUM **YOU PAY**
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 **YOU PAY**
Office visits for adult and pediatric care \$20 per visit
Well-baby care, birth up to two years Covered in full
Maternity care, after the initial diagnosis, pre and post-natal visits Covered in full
Immunizations, adult and pediatric Covered in full
Periodic physical examinations \$20 per visit
Office visits for consultation or care by a non-primary provider when referred by your primary care physician \$20 per visit
Allergy testing \$20 per visit
Eye and hearing examinations \$20 per visit
Family planning services \$20 per visit

OUTPATIENT SERVICES **YOU PAY**
Outpatient surgery (performed in office setting) \$20 per visit
Outpatient surgery (facility) \$100 per visit
Laboratory, X-ray, electrocardiograms and all other tests Covered in full
Therapeutic injections, including allergy shots \$5 per visit
All generally accepted cancer screening tests Covered in full

HOSPITALIZATION SERVICES **YOU PAY**
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: Covered in full
• 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
• Rehabilitation services
Professional inpatient services, including: Covered in full
• Physicians' services, including surgeons, anesthesiologists and consultants
• Private-duty nurse when prescribed by a participating physician

Premier 20

COPAYMENT SUMMARY — A uniform health plan benefit and coverage matrix



URGENT AND EMERGENCY SERVICES

YOU PAY

Outpatient care to treat an injury or the sudden onset of an acute illness within or out of the WHA Service Area:	
Physician's office	\$20 per visit
Urgent care center	\$35 per visit
Hospital emergency room (waived if admitted)	\$100 per visit
Ambulance service as medically necessary or in a life-threatening emergency (including 911)	Covered in full

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

YOU PAY

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	\$20

MENTAL HEALTH AND CHEMICAL DEPENDENCY

YOU PAY

Outpatient Mental Health and Substance Abuse (combined benefit):	
Outpatient service for evaluation and short-term care, up to 20 visits in a calendar year	\$20 per visit
Inpatient mental health: Inpatient hospital services provided at a participating acute care facility for the treatment of psychiatric disorders when authorized in advance by WHA, up to 20 days per calendar year	Covered in full
Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility	Covered in full

SEVERE MENTAL ILLNESS

Copayments and deductibles for Severe Mental Illnesses and Serious Emotional Disturbance of Children (SED) are the same as for any other illness when authorized in advance by WHA. Severe Mental Illness diagnoses include: Schizophrenia, Schizoaffective Disorder, Pervasive Developmental Disorder or Autism, Obsessive-Compulsive Disorder, Panic Disorder, Major Depressive Disorder, Bipolar Disorder, Anorexia Nervosa and Bulimia Nervosa.

HOME HEALTH SERVICES

YOU PAY

Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year	Covered in full
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OTHER HEALTH SERVICES

YOU PAY

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	Covered in full
Short-term rehabilitative services including physical therapy, speech therapy, occupational therapy, cardiac therapy and pulmonary therapy, when authorized in advance by WHA and determined to lead to continued improvement:	
Outpatient rehabilitation	\$20 per visit
Inpatient rehabilitation	Covered in full
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.

Advantage 40

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DEDUCTIBLE

Deductible amount None

YOU PAY

ANNUAL OUT-OF-POCKET MAXIMUM

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 \$3,000

Family \$5,000

YOU PAY

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

Lifetime maximum None

PROFESSIONAL SERVICES

Office visits for adult and pediatric care \$40 per visit

Well-baby care, birth up to two years Covered in full

Maternity care, after the initial diagnosis, pre and post-natal visits Covered in full

Immunizations, adult and pediatric Covered in full

Periodic physical examinations \$40 per visit

Office visits for consultation or care by a non-primary provider when referred by your primary care physician \$40 per visit

Allergy testing \$40 per visit

Eye and hearing examinations \$40 per visit

Family planning services \$40 per visit

YOU PAY

OUTPATIENT SERVICES

Outpatient surgery (performed in office setting) \$40 per visit

Outpatient surgery (facility) 30% copay**

Laboratory, X-ray, electrocardiograms and all other tests Covered in full

Therapeutic injections, including allergy shots \$5 per visit

All generally accepted cancer screening tests Covered in full

YOU PAY

HOSPITALIZATION SERVICES

Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: 30% copay**

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

- Rehabilitation services

Professional inpatient services, including: Covered in full

- Physicians' services, including surgeons, anesthesiologists and consultants

- Private-duty nurse when prescribed by a participating physician

Advantage 40

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Physician's office	\$40 per visit
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Hospital emergency room (waived if admitted)	\$100 per visit
Ambulance service as medically necessary or in a life-threatening emergency (including 911)	Covered in full

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