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	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	$20 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	$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	COST TO MEMBER
Outpatient surgery (performed in office setting)	$20 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	
• Rehabilitation services	
Professional inpatient services, including:	None
• Physicians' services, including surgeons, anesthesiologists and consultants	
• Private-duty nurse when prescribed by a participating physician	

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URGENT AND EMERGENCY SERVICES	COST TO MEMBER
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)	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	$20

MENTAL HEALTH AND CHEMICAL DEPENDENCY	COST TO MEMBER
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	None
Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility	None

SEVERE MENTAL ILLNESS

Copayments and deductibles for Severe Mental Illness 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	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
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	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.