

# Western 2800: 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 if enrolled as Single Member only	\$2,800
Amount if enrolled as 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. If you have family coverage, there is no single deductible for each family member; rather, the entire family deductible must be met before WHA becomes responsible for providing covered services for any individual member in the family. Amounts paid for non-covered services do not count toward a member's deductible.

**ANNUAL OUT-OF-POCKET MAXIMUM**

Amount if enrolled as Single Member only	\$4,000
Amount if enrolled as 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. If you have family coverage, there is no single out-of-pocket maximum for each family member; rather, the entire Family out-of-pocket maximum must be met before you do not have to pay any more copayments for that calendar year. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

Lifetime maximum	None
------------------	------

**YOU PAY**  
UNTIL OUT-OF-POCKET  
MAXIMUM IS MET

**PREVENTIVE CARE SERVICES** (PREVENTIVE CARE SERVICES ARE NOT SUBJECT TO DEDUCTIBLE)

Periodic physical examinations (office visit only)	\$40 per visit
Immunizations, adult and pediatric	Covered in full
Maternity care, after the initial diagnosis, pre and post-natal visits	Covered in full
Well-baby care, birth up to two years	Covered in full
Eye and hearing examinations	\$40 per visit
Breast, cervical and prostate cancer screenings	Covered in full

**YOU PAY**  
AFTER DEDUCTIBLE  
IS MET

**PROFESSIONAL SERVICES**

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

**OUTPATIENT SERVICES**

Outpatient surgery (performed in office setting)	\$40 per visit
Outpatient surgery (facility)	\$250 per visit
Laboratory, X-ray, electrocardiograms and all other tests	Covered in full
Therapeutic injections, including allergy shots	\$5 per visit
All other cancer screening	Covered in full



# Western 2800: AN HSA COMPATIBLE PLAN

## COPAYMENT SUMMARY — *A uniform health plan benefit and coverage matrix*

**YOU PAY**  
AFTER DEDUCTIBLE  
IS MET

### HOSPITALIZATION SERVICES

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 and nursery care for newborn babies	
• Blood transfusion services	
Professional inpatient services, including: . . . . .	Covered in full
• Physicians' services, including surgeons, anesthesiologists and consultants	
• Private-duty nurse when prescribed by a participating physician	

### URGENT AND EMERGENCY SERVICES

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 . . . . .	\$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) . . . . .	Covered in full

### PRESCRIPTION COPAYMENTS FOR COVERED MEDICATIONS

Walk-In Pharmacy (30 day supply)	
Preferred generic medications . . . . .	\$10
Preferred brand name medications . . . . .	\$30
Non-Preferred medications . . . . .	\$50
Mail Order (90 day supply)	
Preferred generic medications . . . . .	\$20
Preferred brand name medications . . . . .	\$60
Non-preferred medications . . . . .	\$100

### DURABLE MEDICAL EQUIPMENT (DME)

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

### MENTAL HEALTH AND CHEMICAL DEPENDENCY

Outpatient Mental Health and Substance Abuse (combined benefit):	
Outpatient service for evaluation and short-term care, up to 20 visits in a calendar year . . . . .	\$40 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 . . . . .	\$500 per day
Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility . . . . .	\$500 per day

### SEVERE MENTAL ILLNESS

Coverage for Severe Mental Illnesses and Serious Emotional Disturbance of Children (SED) 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).	
Outpatient Severe Mental Health: Outpatient services for evaluation and short-term care (unlimited visits) . . . . .	\$40 per visit
Inpatient Severe Mental Health: Inpatient hospital services provided at a participating acute care facility for the treatment of severe psychiatric disorders as listed above, when authorized in advance by WHA (unlimited days) . . . . .	\$500 per day

# Western 2800: AN HSA COMPATIBLE PLAN

COPAYMENT SUMMARY — *A uniform health plan benefit and coverage matrix*



**YOU PAY**  
AFTER DEDUCTIBLE  
IS MET

## HOME HEALTH SERVICES

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

## OTHER HEALTH SERVICES

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

Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:

Outpatient rehabilitation. . . . . \$40 per visit

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, are not included in this deductible or annual out-of-pocket maximum.

The charges you pay for services that are subject to a deductible or percentage copayments, are based upon WHA's contracted rates with our participating providers and medical groups.

To see how much you have paid toward your annual deductible, log onto WHA's website at [westernhealth.com](http://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

Regardless of medical necessity or generic availability, you will be responsible for the Brand Name (Preferred or Non-Preferred) copayment when a Brand Name Medication is dispensed. If a Generic Medication is available and you elect to receive a Brand Name Medication without medical indication from the prescribing physician, you will be responsible for the difference in cost between Generic and Brand Name in addition to the Generic copayment.

### COVERED PRESCRIPTION MEDICATIONS

- 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, which contain at least one Prescription ingredient.
- Insulin, insulin syringes with needles, glucose test strips and tablets.
- Oral and patch contraceptives and diaphragms.
- Prenatal Prescription vitamins or vitamins in conjunction with fluoride.
- Pediatric asthma supplies and devices.



# Western 2800: AN HSA COMPATIBLE PLAN

## COPAYMENT SUMMARY — *A uniform health plan benefit and coverage matrix*

### **PRESCRIPTION DEFINITIONS**

**“Preferred Drug List (PDL)”** is a preferred listing of medications developed by WHA’s Pharmacy & Therapeutics (P&T) Committee as drugs of choice in their respective classes of Preferred Generic, Preferred Brand Name or Non-Preferred Medications. Members may request a copy of the PDL from WHA Member Services or view the document on the website: [westernhealth.com](http://westernhealth.com).

**“Three-Tier Copay Plan”** means Preferred Generic Medications listed on the PDL are covered at the lowest copay, Preferred Brand Name Medications listed on the PDL are provided at the second copayment level. Drugs not listed on the PDL are covered at the third tier copayment level. There are a small number of drugs, regardless of tier level, that may require prior authorization to ensure the appropriate use based on criteria set by the WHA P&T Committee.

*Please note:* The listing of a drug on the WHA PDL does not guarantee that the member’s physician will prescribe the drug.

### **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.