



**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**

In any calendar year we will not cover certain services until member meets the following deductibles:

Medical (including inpatient, outpatient surgery and emergency services) .....	\$1,000 for one member or \$2,000 for family
Pharmacy (for Preferred brand name or Non-Preferred medications) .....	\$150 per member

**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 .....	\$4,000
Family .....	\$8,000

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

Lifetime maximum .....	None
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**PROFESSIONAL SERVICES**

**YOU PAY**

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

**OUTPATIENT SERVICES**

**YOU PAY**

Outpatient surgery (performed in office setting) .....	\$40 per visit
Outpatient surgery (facility) .....	\$250 per visit after deductible <sup>+</sup>
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: .....	\$500 per day after deductible <sup>+</sup>
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- 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
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- Physicians' services, including surgeons, anesthesiologists and consultants
- Private-duty nurse when prescribed by a participating physician



### 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	\$40 per visit
Urgent care center	\$50 per visit
Hospital emergency room (waived if admitted)	\$100 per visit after deductible <sup>+</sup>
Ambulance service as medically necessary or in a life-threatening emergency (including 911)	Covered in full

### PRESCRIPTION COVERAGE W\* (See Prescription W Copayment Summary for complete information)

### YOU PAY

Walk-In Pharmacy (30 day supply)	
Preferred generic medications	\$10
Preferred brand name medications	\$30 after deductible <sup>+</sup>
Non-Preferred medications	\$50 after deductible <sup>+</sup>

### DURABLE MEDICAL EQUIPMENT (DME)

### 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	\$40

### 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	\$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 after deductible <sup>+</sup>
Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility	\$500 per day after deductible <sup>+</sup>

### 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	\$500 per day after deductible <sup>+</sup>
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	\$40 per visit
Inpatient rehabilitation	\$500 per day after deductible <sup>+</sup>
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).*	

<sup>+</sup> These services are subject to a Deductible. You must pay for these services when you receive them, until you meet your Deductible. Charges under the Deductible are based on WHA's contracted rates with the Provider of Service.

\*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 rates.

# Prescription W

## COPAYMENT SUMMARY



Western Health Advantage (WHA) shall cover Prescription medications at Participating Pharmacies, prescribed in connection with a covered service and subject to conditions, limitations and exclusions stated in this Copayment Summary.

### DEDUCTIBLE

In any calendar year we will not cover Preferred or Non-Preferred Brand Name medication until member meets the following deductible

### YOU PAY

\$150 per member during that calendar year

### PRESCRIPTION COPAYMENTS FOR COVERED MEDICATIONS

### YOU PAY

WHA offers a Three-tier Copay Plan (see definitions)

Walk-In Pharmacy (up to 30 day supply)

- Preferred Generic medication .....\$10
- Preferred Brand Name medication\*.....\$30 after deductible
- Non-Preferred medication\* .....\$50 after deductible

Mail Order (up to 90 day supply)

- Preferred Generic medication .....\$20
- Preferred Brand Name medication\*.....\$60 after deductible
- Non-Preferred medication\* .....\$100 after deductible

\*Regardless of medical necessity or Generic availability, the member 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 the member elects to receive a Brand Name medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between Generic and Brand Name in addition to the Generic copayment.

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.

Prescription copayments do not contribute to the medical annual out-of-pocket maximum (unless required for diabetes supplies or pediatric asthma supplies and equipment).

### COVERED PRESCRIPTION MEDICATIONS

- Oral 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 (the receipt may be submitted to WHA for reimbursement).
- Compounded Prescriptions which contain at least one Prescription ingredient.
- Insulin, insulin syringes with needles, glucose test strips and tablets.
- Oral contraceptives and diaphragms.
- Prenatal Prescription vitamins or vitamins in conjunction with fluoride.

### DEFINITIONS

**Brand Name medication** is a Prescription drug manufactured, marked, and sold under a given name.

**FDA-approved** means that drugs, medications, and biologicals have been approved by the United States Food and Drug Administration (FDA) and are listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

**Generic medication** is a Prescription drug that is medically equivalent to a Brand Name medication as determined by the FDA and meets the same standards as a Brand Name medication in all facets: purity, safety, strength and effectiveness.

**Maintenance medication** is any covered Prescription medication that is to be taken beyond 60 days. Examples include medications for high blood pressure, diabetes, arthritis, allergy and oral contraceptives.

**Participating Pharmacy** is a pharmacy under contract with WHA, authorized to dispense covered Prescription medications to members who are entitled under the pharmacy benefit to receive them. Refer to the WHA Provider Directory for a list of Participating Pharmacies.

**Preferred Drug List (PDL)** is a listing of medications developed by WHA's Pharmacy and Therapeutics (P&T) Committee as drugs of choice in their respective classes of Preferred Generic medication or Preferred Brand Name medication.

Drugs are evaluated regularly by the P&T Committee, which meets every other month, to determine the additions and possible deletions of medications and to ensure rational and cost effective use of pharmaceutical agents. Physicians may request that the P&T Committee consider adding specific medications to the PDL. The Committee reviews all medications for their efficacy, quality, safety, similar alternatives, and cost in determining their inclusion on the PDL.

**Prescription medication** is a drug which has been approved by the FDA and which can, under federal or state law, be dispensed only pursuant to a Prescription order from a physician who is duly licensed to do so.

**Prescription** is a written or oral order for a Prescription medication directly related to the treatment of an illness or injury and is issued by the attending physician within the scope of his or her professional license.

**Three-tier Copay Plan** means Preferred Generic medications listed on the PDL are covered at the lowest tier copayment level, Brand Name medications listed on the PDL are provided at the second tier copayment level, and drugs not listed on the PDL are covered at the third tier copayment level. There are a small number of drugs, regardless of tier, that may require prior authorization to ensure appropriate use based on criteria set by the WHA P&T Committee. Please note that a drug's presence on the WHA PDL does not guarantee that the member's physician will prescribe the drug. Members may request a copy of the PDL by calling WHA Member Services or view the document on WHA's website at [westernhealth.com](http://westernhealth.com).

### PRINCIPAL EXCLUSIONS AND LIMITATIONS

The covered Prescription medications are subject to the exclusions and limitations described in this section:

- a. Generic medications are required. The pharmacist will automatically substitute an equivalent Generic medication for the prescribed Brand Name medication (Preferred or Non-Preferred) unless: your physician writes, "do not substitute" or "prescribe as written"; there is not a generic equivalent available; or the medication is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalency issues. In these cases, the member will be provided the Brand Name medication as written by the member's physician, even if a Generic is available. The Brand Name copayment will apply. A member may request a list of applicable NTI drugs by calling WHA Member Services.
- b. Some Prescription medications may require prior authorization by WHA. For clarification, please contact WHA Member Services. Routine/non-urgent requests for prior authorization are processed within three business days if all applicable information is included with the request. Requests that are indicated as urgent will be reviewed within one business day. An incomplete request may delay the authorization process if the provider is not available to supply the necessary clinical information. For a prior authorization request after business hours or on weekends and holidays in an urgent or emergency situation, the Pharmacy is authorized to dispense an emergency short supply of the medication.
- c. Covered Prescription medications are limited to a 30 day supply at a participating pharmacy. A 90 day supply of oral Maintenance medications is available through WHA's Mail Order program (see item d). Oral specialty medications that cost over \$500 for a 30 day supply are limited to a 30 day supply.
- d. Covered Prescription medications that are to be taken beyond 60 days are considered Maintenance medications and may be obtained through the Mail Order program. The initial Prescription for Maintenance medications may be dispensed through a Participating Pharmacy (limited to a 30 day supply). Subsequent refills for a 90 day supply may be obtained through the Mail Order program.
- e. Over-the-counter medications or medications that do not require a Prescription are excluded (except for insulin and insulin syringes with needles for diabetics).
- f. Medications that are not medically necessary are excluded.
- g. Treatment of impotence and/or sexual dysfunction must be medically necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to the Plan for review. Drugs and medications are limited to eight (8) pills per month for a 30 day period and are subject to a 50% copayment.
- h. Medications that are experimental or investigational are excluded, except for life-threatening or seriously debilitating conditions and cancer clinical trials as described in the Combined Evidence of Coverage and Disclosure Form (EOC/DF) under the section titled, "Appeal for Investigational/Experimental Treatment".
- i. There are a small number of drugs, regardless of PDL tier level, that may require prior authorization for a non-FDA approved indication (off label use). For off label use, the medication must be FDA approved for some indication and recognized by the AMA Drug Evaluations, the American Hospital Formulary Service Drug Information, the United States Pharmacopoeia Dispensing Information (vol. 1, Drug Information for the Health Care Professional) or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective, unless there is clear and convincing contradictory evidence in a similar journal.
- j. Prescriptions written by dentists are excluded.
- k. Drugs required for foreign travel are excluded, unless they are prior authorized for medical necessity.
- l. Prescription products for cosmetic indications, including agents for wrinkles or hair growth, and over-the-counter dietary/nutritional aids and health/beauty aids are excluded.
- m. Drugs used for weight loss and dietary/nutritional aids which require a prescription are excluded, unless they are prior authorized for medical necessity.
- n. Contraceptive devices (including IUD's) and implantable contraceptives, such as Norplant, are not covered under this prescription rider benefit; they are covered under the medical benefit as described in the EOC/DF.
- o. Medications for injection or implantation (except insulin and other medications as determined by WHA) are covered under the medical benefit as described in the EOC/DF under the sections titled "Outpatient Services" and "Diabetes supplies, equipment and services".
- p. Pharmacies which dispense covered Prescription medications to members pursuant to the Agreement and this prescription rider benefit, do so as independent contractors. WHA shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by members.
- q. WHA shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing, or use of any covered Prescription medication.
- r. Medications for the treatment of infertility are excluded, unless the employer has added an Infertility rider benefit.
- s. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride) are excluded.
- t. Medications for the treatment of short stature, unless medically necessary.
- u. Replacement medications for drugs that are lost or stolen are not covered.

### PRESCRIPTION CLAIM REIMBURSEMENT

If a member pays for a covered Prescription medication as described in this Copayment Summary, the original receipt along with a copy of the member's identification card, address, a daytime telephone number, and the reason for the reimbursement request should be submitted to WHA within 60 days of purchase. No claim will be considered if submitted after 12 months from the date of purchase.