Benefit Summary Guide

Health Plan Information for Employer Groups
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Introduction

Better Value
Western Health Advantage is a not-for-profit health plan created by local health providers. By operating locally, we spare providers and patients the expense and frustration of typical HMO bureaucracy. And without the requirement of profitability beyond operating expenses, we are able to provide affordable care without sacrificing quality or service. The real benefit of WHA is not just our competitive premium but the value that it brings.

Better Service
When people are not well, they don’t want to wait long for help. If a patient with acute medical needs finds her Primary Care Physician unavailable, Western Health Advantage offers guaranteed access to another Primary Care Physician within one working day.

People appreciate flexibility in choosing a physician. Our members have quick access to over 500 Primary Care Physicians and more than 1,400 specialty care providers within the counties of Sacramento, Yolo, Solano, western El Dorado and western Placer.

A special feature of WHA is our Advantage Referral program. Our members can obtain referrals to most specialists throughout the entire WHA network, not just those in their Primary Care Physician’s medical group (refer to Access to Care below).

At Western Health Advantage, we feel a runaround is good for exercise, not service.

Better Quality
When employers choose from the wide range of WHA coverage options, their people gain access to many of the area’s best medical groups. These include:

- UC Davis Medical Group
- Mercy Medical Group
- NorthBay Center for Primary Care
- Woodland Clinic Medical Group
- Hill Physicians Medical Group
- Golden State Medical Group
- Sutter Regional Medical Foundation (Solano County)

Note: Sutter Regional Medical Foundation is not available to those who participate in the HSA compatible plans.
Learn More
To learn more about the various plan options you can provide to your employees, or if you simply have questions about the information in this guide, please contact your insurance broker or WHA directly at 916.563.3198. Employers may also visit us at westernhealth.com.

Access to Care

Answers to Common Questions

Who can be a WHA member's Primary Care Physician (PCP)?
A member’s PCP can be a Family Practitioner, Internist, General Medicine Practitioner, or Pediatrician within the WHA network. Each family member can choose a PCP from different medical groups. The PCP is responsible for coordinating all of a member’s medical care needs and authorizing referrals to access specialists.

What happens if a member needs to see a specialist?
The PCP will refer the member when services from a specialist are required. Members can self-refer within the network for annual eye exams and OB/GYN visits.

Is a member limited to only the specialists in the PCP’s medical group?
Typically, the PCP will refer the member within the medical group. However, the WHA Advantage Referral program allows patients to select a PCP in one medical group, but when referred for specialty care, patients may elect to see most specialists in any of the other WHA medical groups. This program provides choice and flexibility while eliminating the frustration patients often experience in other HMO plans when they can not see a specialist outside their PCP’s medical group. Women may also choose a participating OB/GYN from another WHA medical group (refer to the Provider Directory to ensure the specialist participates in the Advantage Referral program).

What if a Member has an out-of-area emergency?
WHA covers the member for urgent care and emergency care services worldwide, less the applicable copayment.

Emergency room visits are not covered for non-emergency situations. It is important to note that care that could have been foreseen prior to leaving the WHA service area, such as routine care, physical examinations, diagnostic test or preventative procedures, is not covered.

If the emergency health problem requires a specialist, the PCP will refer the member to an appropriate Participating Provider as needed. All other care must be performed within the service area by a contracted provider.
Are dependents covered while attending college away from home?
Coverage can be extended to full-time students at an accredited institution of higher learning. Full-time students who reside outside the service area to attend school are not covered for services received outside the service area, except in an urgent care or emergency care situation.

What if a member lives out of the WHA Service Area?
WHA is pleased to welcome new members who work in the health plan’s service area, but who may be living on the borders or outside the county boundaries in which WHA is licensed for business. It is important for these commuters to understand that their PCP’s office needs to be located within the service area and that they are required to receive all routine and preventative services there. This includes care required for routine illnesses such as colds, flu, headaches, minor sprains and other illnesses and injuries that are not classified as urgent or emergency care.

Please consult the Combined Evidence of Coverage and Disclosure Form (EOC) for a more detailed description of these limitations.

Contact Us

Western Health Advantage  westernhealth.com
  888.227.5942 toll-free phone
  916.568.1338 fax

WHA Sales Department  whasales@westernhealth.com
  916.563.3198 phone
  916.568.1338 fax

WHA Member Service Department  memberservices@westernhealth.com
  888.563.2250 toll-free phone
  916.563.2250 phone
  916.568.0126 fax

WHA Premium Accounting  whafinance@westernhealth.com
  916.563.2206 phone
  916.568.0331 Finance fax
  916.568.0334 Eligibility fax
Premier Plans

- Premier 5 – available to Large Group employers only (51+ employees)
- Premier 10
- Premier 15
- Premier 20
- Premier 40
- Premier Medicare Supplement 10 – available to groups with 2 - 19 full-time employees

All plans include:

**Behavioral Health Services:** covering Mental Health, Severe Mental Illness and Substance Abuse benefits

Covered through Magellan Behavioral Health, Inc.
800.424.1778  magellanhealth.com

**Complementary Alternative Medicine (CAM) benefits:** offering Acupuncture and Chiropractic benefits

Administered by Landmark Healthplan of California, Inc.
800.638.4557  landmarkhealthcare.com
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**DEDUCTIBLE**

Deductible amount ................................................................. None

**ANNUAL OUT-OF-POCKET MAXIMUM**

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

The maximum out-of-pocket expense for Members per calendar year is limited to:

- Individual ................................................................. $750
- Family ................................................................. $1,500
- Lifetime maximum ................................................................. None

**PROFESSIONAL SERVICES**

- Office visits for adult and pediatric care ................................................................. $5
- 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 ................................................................. $5 per visit
- Office visits for consultation or care by a non-primary provider when referred by your primary care physician ................................................................. $5 per visit
- Allergy testing ................................................................. $5 per visit
- Eye and hearing examinations ................................................................. $5 per visit
- Family planning services ................................................................. $5 per visit

**OUTPATIENT SERVICES**

- Outpatient surgery (performed in office setting) ................................................................. $5 per visit
- Outpatient surgery (facility) ................................................................. $50 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**

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

- 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:

- 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: $5 per visit
- Urgent care center: $15 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

Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

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: $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

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): $5 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): Covered in full

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: Covered in full

- Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:
  - Outpatient rehabilitation: $5 per visit
  - Inpatient rehabilitation: Covered in full

- Home self injectables, up to $100 maximum copay per 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.
# Copayment Summary — Premier 10

**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

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Deductible amount</td>
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## Annual Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Individual</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$2,500</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
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</tbody>
</table>

## Professional Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits for adult and pediatric care</td>
<td>$10</td>
</tr>
<tr>
<td>Well-baby care, birth up to two years</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Maternity care, after the initial diagnosis, pre and post-natal visits</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Immunizations, adult and pediatric</td>
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<tr>
<td>Periodic physical examinations</td>
<td>$10 per visit</td>
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<td>Office visits for consultation or care by a non-primary provider when referred by your primary care physician</td>
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## Outpatient Services

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## Hospitalization Services

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### 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: $10 per visit
- Urgent care center: $20 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

Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA:

- 20% copay*

### 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: $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
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### SEVERE MENTAL ILLNESS

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### 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: Covered in full

- Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:
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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.
**Premier 15**  
**COPAYMENT SUMMARY — A uniform health plan benefit and coverage matrix**

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPAR**E **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.**

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<td>$20 per visit</td>
</tr>
<tr>
<td>Family planning services</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery (performed in office setting)</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Outpatient surgery (facility)</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Laboratory, X-ray, electrocardiograms and all other tests</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Therapeutic injections, including allergy shots</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>All generally accepted cancer screening tests</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalization Services</strong></td>
<td></td>
</tr>
<tr>
<td>Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:</td>
<td>Covered in full</td>
</tr>
<tr>
<td>• Newborn delivery (private room when determined medically necessary by a participating provider)</td>
<td></td>
</tr>
<tr>
<td>• Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborn babies</td>
<td></td>
</tr>
<tr>
<td>• Blood transfusion services</td>
<td></td>
</tr>
<tr>
<td>Professional inpatient services, including:</td>
<td>Covered in full</td>
</tr>
<tr>
<td>• Physicians’ services, including surgeons, anesthesiologists and consultants</td>
<td></td>
</tr>
<tr>
<td>• Private-duty nurse when prescribed by a participating physician</td>
<td></td>
</tr>
</tbody>
</table>
**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: $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**

Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

**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: $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 dependence: Short-term inpatient detoxification only, at a WHA acute care facility: Covered in full

**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): $20 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): Covered in full

**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: Covered in full

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

- Outpatient rehabilitation: $20 per visit
- Inpatient rehabilitation: Covered in full

Home self injectables, up to $100 maximum copay per 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).*
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.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible amount</td>
<td>None</td>
</tr>
</tbody>
</table>

### Annual Out-of-Pocket Maximum

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

The maximum out-of-pocket expense for Members per calendar year is limited to:

<table>
<thead>
<tr>
<th>Category</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$2,500</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
</tr>
</tbody>
</table>

### Professional Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits for adult and pediatric care</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Well-baby care, birth up to two years</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Maternity care, after the initial diagnosis, pre and post-natal visits</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Immunizations, adult and pediatric</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Periodic physical examinations</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Office visits for consultation or care by a non-primary provider when referred by your primary care physician</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>$40 per visit</td>
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<tr>
<td>Eye and hearing examinations</td>
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### Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
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</thead>
<tbody>
<tr>
<td>Outpatient surgery (performed in office setting)</td>
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<td>Outpatient surgery (facility)</td>
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<tr>
<td>Laboratory, X-ray, electrocardiograms and all other tests</td>
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<td>All generally accepted cancer screening tests</td>
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</table>

### Hospitalization Services

<table>
<thead>
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<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:</td>
<td>Covered in full</td>
</tr>
<tr>
<td>- Newborn delivery (private room when determined medically necessary by a participating provider)</td>
<td>Covered in full</td>
</tr>
<tr>
<td>- Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborn babies</td>
<td>Covered in full</td>
</tr>
<tr>
<td>- Blood transfusion services</td>
<td>Covered in full</td>
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<tr>
<td>Professional inpatient services, including:</td>
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</tr>
<tr>
<td>- Physicians’ services, including surgeons, anesthesiologists and consultants</td>
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<tr>
<td>- Private-duty nurse when prescribed by a participating physician</td>
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</table>
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 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
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

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: Covered in full
- Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: Covered in full

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): Covered in full

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: Covered in full
- 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: Covered in full
- Home self injectables, up to $100 maximum copay per 30 day supply (Insulin is covered under the prescription benefit): 20% copay*

*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.
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
Deductible amount .......................................................................................................................... None

ANNUAL OUT-OF-POCKET MAXIMUM
All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.
The maximum out-of-pocket expense for Members per calendar year is limited to:
Individual ........................................................................................................................................... $1,000
Family ............................................................................................................................................... $2,500
Lifetime maximum ............................................................................................................................ None

PROFESSIONAL SERVICES
Office visits for adult and pediatric care ....................................................................................... $10 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 ........................................................................................................ $10 per visit
Office visits for consultation or care by a non-primary provider when referred by your primary care physician .......................................................................................................................... $10 per visit
Allergy testing .................................................................................................................................. $10 per visit
Eye and hearing examinations ......................................................................................................... $10 per visit
Family planning services ................................................................................................................ $10 per visit

OUTPATIENT SERVICES
Outpatient surgery (performed in office setting) ........................................................................... $10 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
Medicare allows 90 days per benefit period and an additional 60 lifetime reserve days; WHA provides an additional 365 days after Medicare lifetime reserve days are used.
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:

- 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:

- 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: $10 per visit
- Urgent care center: $20 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
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

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: $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
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): $10 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): Covered in full

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: Covered in full

- Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:
  - Outpatient rehabilitation: $10 per visit
  - Inpatient rehabilitation: Covered in full

- Home self injectables, up to $100 maximum copay per 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 Plans

- Advantage 15-30
- Advantage 420
- Advantage 70
- Advantage 40

All plans include:

**Behavioral Health Services**: covering Mental Health, Severe Mental Illness and Substance Abuse benefits
  Covered through Magellan Behavioral Health, Inc.
  800.424.1778  magellanhealth.com

**Complementary Alternative Medicine (CAM) benefits**: offering Acupuncture and Chiropractic benefits
  Administered by Landmark Healthplan of California, Inc.
  800.638.4558  landmarkhealthcare.com
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
Deductible amount ................................................................. None

ANNUAL OUT-OF-POCKET MAXIMUM
All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.
The maximum out-of-pocket expense for Members per calendar year is limited to:
Individual ................................................................. $1,500
Family ................................................................. $2,500
Lifetime maximum ................................................................. None

PROFESSIONAL SERVICES
Office visits for adult and pediatric care ................................................................. $15-30 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 ................................................................. $15-30 per visit*
Office visits for consultation or care by a non-primary provider when referred by your primary care physician ................................................................. $30 per visit*
Allergy testing ................................................................. $15-30 per visit*
Eye and hearing examinations ................................................................. $15-30 per visit*
Family planning services ................................................................. $15-30 per visit*

OUTPATIENT SERVICES
Outpatient surgery (performed in office setting) ................................................................. $15-30 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
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: ................................................................. $250 per day, days 1-3

• 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: $15-30 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 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
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

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: $30 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: $250 per day, days 1-3
Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: $250 per day, days 1-3

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): $30 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): $250 per day, days 1-3

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: $250 per day, days 1-3
Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:

Outpatient rehabilitation: $30 per visit
Inpatient rehabilitation: $250 per day, days 1-3
Home self injectables, up to $100 maximum copay per 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).*

* Primary Care Physician Copayment $15 — Specialist Copayment $30
*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.
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**

Deductible amount ................................................................. None

**ANNUAL OUT-OF-POCKET MAXIMUM**

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

The maximum out-of-pocket expense for Members per calendar year is limited to:

- Individual ................................................................. $2,500
- Family ................................................................. $4,500
- Lifetime maximum ................................................................. None

**PROFESSIONAL SERVICES**

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**

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**

Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: ................................................................. $500 per day, days 1-5

- 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: $20 per visit
- Urgent care center: $35 per visit
- Hospital emergency room (waived if admitted): $100 per visit
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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
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

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: $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: $500 per day, days 1-5
- Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: $500 per day, days 1-5

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):
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- 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, days 1-5

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, days 1-5
- Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:
  - Outpatient rehabilitation: $20 per visit
  - Inpatient rehabilitation: $500 per day, days 1-5
- Home self injectables, up to $100 maximum copay per 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.
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**DEDUCTIBLE**
Deductible amount ................................................................. None

**ANNUAL OUT-OF-POCKET MAXIMUM**
All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.
The maximum out-of-pocket expense for Members per calendar year is limited to:

- Individual ................................................................. $3,000
- Family ................................................................. $5,000
- Lifetime maximum ................................................................. None

**PROFESSIONAL SERVICES**
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**
Outpatient surgery (performed in office setting) ................................................................. $20 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

**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
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

**You Pay**

- **Physician’s office:** $20 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 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 (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

### 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: 30% copay**
  - Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: 30% copay**

### 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): $20 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): 30% copay**

### 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

**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: 30% copay**
- Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:
  - Outpatient rehabilitation: $20 per visit
  - Inpatient rehabilitation: 30% copay**
- Home self injectables, up to $100 maximum copay per 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).*

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*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.**

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*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.**
### Copayment Summary — Advantage 40

**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

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible amount</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Annual Out-of-Pocket Maximum

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

The maximum out-of-pocket expense for Members per calendar year is limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Professional Services

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits for adult and pediatric care</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Well-baby care, birth up to two years</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Maternity care, after the initial diagnosis, pre and post-natal visits</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Immunizations, adult and pediatric</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Periodic physical examinations</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Office visits for consultation or care by a non-primary provider when referred by your primary care physician</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Eye and hearing examinations</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Family planning services</td>
<td>$40 per visit</td>
</tr>
</tbody>
</table>

#### Outpatient Services

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery (performed in office setting)</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Outpatient surgery (facility)</td>
<td>30% copay**</td>
</tr>
<tr>
<td>Laboratory, X-ray, electrocardiograms and all other tests</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Therapeutic injections, including allergy shots</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>All generally accepted cancer screening tests</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

#### Hospitalization Services

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:</td>
<td>30% copay**</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborn delivery (private room when determined medically necessary by a participating provider)</td>
<td>30% copay**</td>
</tr>
<tr>
<td>Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborn babies</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion services</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Professional inpatient services, including:</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Physicians’ services, including surgeons, anesthesiologists and consultants</td>
<td></td>
</tr>
<tr>
<td>Private-duty nurse when prescribed by a participating physician</td>
<td></td>
</tr>
</tbody>
</table>
## 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 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

Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA:

- 20% copay*

## 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: 30% copay**
- Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: 30% copay**

## 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): 30% copay**

## 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: 30% copay**

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: 30% copay**

Home self injectables, up to $100 maximum copay per 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).*

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*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.

** Percentage copayment amounts are based on WHA’s contracted rate.
Western Plans
(high deductible plans)

- Western 4010
- Western 2025
- Western 4025
- Western 2800 – an HSA compatible plan
- Western 2800B – an HSA compatible plan

Plans include:

**Behavioral Health Services**: covering Mental Health, Severe Mental Illness and Substance Abuse benefits
Covered through Magellan Behavioral Health, Inc.
800.424.1778   magellanhealth.com

**Prescription benefits**
Administered by Medco Health Solutions, Inc.
800.903.8664   medcohealth.com

Note:

**WHA endorsed provider for HSA administration**
Sterling HSA
800.617.4729   sterlinghsa.com
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
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
All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.
The maximum out-of-pocket expense for Members per calendar year is limited to:

Individual ................................................................. $4,000
Family ................................................................. $8,000
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

OUTPATIENT SERVICES
Outpatient surgery (performed in office setting) .................................................. $40 per visit
Outpatient surgery (facility) ........................................... $250 per visit after deductible
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
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:

• 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

• Covered in full

$500 per day after deductible
## URGENT AND EMERGENCY SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient care to treat an injury or the sudden onset of an acute illness within or out of the WHA Service Area:</td>
<td></td>
</tr>
<tr>
<td>Physician's office</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Urgent care center</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Hospital emergency room (waived if admitted)</td>
<td>$100 per visit after deductible*</td>
</tr>
<tr>
<td>Ambulance service as medically necessary or in a life-threatening emergency (including 911)</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-In Pharmacy (30 day supply)</td>
<td></td>
</tr>
<tr>
<td>Preferred generic medications</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred brand name medications</td>
<td>$30 after deductible*</td>
</tr>
<tr>
<td>Non-Preferred medications</td>
<td>$50 after deductible*</td>
</tr>
</tbody>
</table>

## DURABLE MEDICAL EQUIPMENT

<table>
<thead>
<tr>
<th>Service</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA</td>
<td>20% copay*</td>
</tr>
</tbody>
</table>

## 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 after deductible*
- Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: $500 per day after deductible*

## 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 Severed Mental Health: Outpatient services for evaluation and short-term care (unlimited visits): $40 per visit
- Inpatient Severed 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 after deductible*

## 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 after deductible*

- 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 after deductible*

Home self injectables, up to $100 maximum copay per 30 day supply (Insulin is covered under the prescription benefit): 20% copay*

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* 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.
**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.**

<table>
<thead>
<tr>
<th>DEDUCTIBLE</th>
<th>YOU PAY</th>
<th>ANNUAL OUT-OF-POCKET MAXIMUM</th>
<th>YOU PAY</th>
<th>PROFESSIONAL SERVICES</th>
<th>YOU PAY</th>
<th>OUTPATIENT SERVICES</th>
<th>YOU PAY</th>
<th>HOSPITALIZATION SERVICES</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>In any calendar year we will not cover certain services until member meets the following deductibles:</td>
<td></td>
<td>All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.</td>
<td></td>
<td>Office visits for adult and pediatric care</td>
<td>Covered in full</td>
<td>Outpatient surgery (performed in office setting)</td>
<td>Covered in full</td>
<td>Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Medical (including inpatient, outpatient surgery and emergency services)</td>
<td>$2,500 for one member or $5,000 for family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy (for Preferred brand name or Non-preferred medications)</td>
<td>$150 per member</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>The maximum out-of-pocket expense for Members per calendar year is limited to:</td>
<td></td>
<td>Office visits for consultation or care by a non-primary provider when referred by your primary care physician</td>
<td>$20 per visit</td>
<td>Newborn delivery (private room when determined medically necessary by a participating provider)</td>
<td>$500 per day after deductible+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$5,000</td>
<td>Covered in full</td>
<td></td>
<td>Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborn babies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$10,000</td>
<td>Covered in full</td>
<td></td>
<td>Blood transfusion services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
<td>Covered in full</td>
<td></td>
<td>Professional inpatient services, including:</td>
<td>Covered in full</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered in full</td>
<td></td>
<td>Physicians’ services, including surgeons, anesthesiologists and consultants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered in full</td>
<td></td>
<td>Private-duty nurse when prescribed by a participating physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• 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: $20 per visit
- Urgent care center: $50 per visit
- Hospital emergency room (waived if admitted): $100 per visit (after deductible)*
- 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)
- Walk-In Pharmacy (30 day supply):
  - Preferred generic medications: $10
  - Preferred brand name medications: $30 after deductible*
  - Non-Preferred medications: $50 after deductible*

## DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 20% copay*

## 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: $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: $500 per day after deductible*
  - Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: $500 per day after deductible*

## 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): $20 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 after deductible*

## 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 after deductible*
- Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:
  - Outpatient rehabilitation: $20 per visit
  - Inpatient rehabilitation: $500 per day after deductible*
- Home self injectables, up to $100 maximum copay per 30 day supply (Insulin is covered under the prescription benefit): 20% copay*

* 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.
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DEDUCTIBLE

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

Medical (including inpatient, outpatient surgery and emergency services) ................................................. $2,500 for one member or
Pharmacy (for Preferred brand name or Non-preferred medications) .................................................. $150 per member

ANNUAL OUT-OF-POCKET MAXIMUM

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

The maximum out-of-pocket expense for Members per calendar year is limited to:

Individual ................................................................. $5,000
Family ..................................................................... $10,000
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

OUTPATIENT SERVICES

Outpatient surgery (performed in office setting) .......................................... $40 per visit
Outpatient surgery (facility) ..................................................................... $250 per visit after deductible
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

Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: $500 per day after deductible

- 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 after deductible
- 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)
- Walk-In Pharmacy (30 day supply)
  - Preferred generic medications: $10
  - Preferred brand name medications: $30 after deductible
  - Non-Preferred medications: $50 after deductible

**DURABLE MEDICAL EQUIPMENT**
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHa: 20% copay

**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 after deductible
- Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHa acute care facility: $500 per day after deductible

**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 after deductible

**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 after deductible

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 after deductible

Home self injectables, up to $100 maximum copay per 30 day supply (Insulin is covered under the prescription benefit): 20% copay

*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.
**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.**

### ANNUAL DEDUCTIBLE

<table>
<thead>
<tr>
<th>Description</th>
<th>Member Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount if enrolled as Single Member only</td>
<td>$2,800</td>
</tr>
<tr>
<td>Amount if enrolled as Family</td>
<td>$5,600</td>
</tr>
</tbody>
</table>

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

<table>
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<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Amount if enrolled as Single Member only</td>
<td>$4,000</td>
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<td>Amount if enrolled as Family</td>
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</table>

The *out-of-pocket maximum* is the maximum total amount of copayments and deductibles that a member and 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

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

<table>
<thead>
<tr>
<th>Description</th>
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<td>Periodic physical examinations (office visit only)</td>
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<td>Immunizations, adult and pediatric</td>
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<td>Well-baby care, birth up to two years</td>
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<td>Eye and hearing examinations</td>
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<td>Breast, cervical and prostate cancer screenings</td>
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**YOU PAY UNTIL OUT-OF-POCKET MAXIMUM IS MET**

### PROFESSIONAL SERVICES

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**YOU PAY AFTER DEDUCTIBLE IS MET**

### OUTPATIENT SERVICES

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<tr>
<td>Laboratory, X-ray, electrocardiograms and all other tests</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Therapeutic injections, including allergy shots</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>All other cancer screening</td>
<td>Covered in full</td>
</tr>
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**YOU PAY AFTER DEDUCTIBLE IS MET**

### MEMBERSHIP RESPONSIBILITY OUT-OF-POCKET COSTS

- The *maximum* is the total amount of out-of-pocket costs a member may have to pay for covered services during any 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 DEDUCTIBLE**

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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.

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Lifetime maximum: None

### PREVENTIVE CARE SERVICES

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

### PROFESSIONAL SERVICES

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**YOU PAY AFTER DEDUCTIBLE IS MET**

### OUTPATIENT SERVICES

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**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:
• 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
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA 20% copay

MENTAL HEALTH AND CHEMICAL DEPENDENCY (combined benefit)
Outpatient Mental Health and Substance Abuse:
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
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 SERVICE
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 (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. 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, patch contraceptives and diaphragms.
- Prenatal Prescription vitamins or vitamins in conjunction with fluoride.
- Pediatric asthma supplies and devices.
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.

“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 presence of a drug listed 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 you consult your tax of financial advisor to determine whether HSAs and this high-deductible health care plan are a good choice for you.
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.

### ANNUAL DEDUCTIBLE

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<th>Type</th>
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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. Each family member in the Family unit must meet the Individual amount before WHA becomes responsible for providing covered services for that individual in the family, unless the family meets the Family amount first. Amounts paid for non-covered services do not count toward a member’s deductible.

### ANNUAL OUT-OF-POCKET MAXIMUM

<table>
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<tr>
<th>Type</th>
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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. Each family member in the Family unit must meet the Individual amount before you do not have to pay any more copayments or deductibles for that calendar year, unless the family meets the Family amount first. Amounts paid for non-covered services do not count toward a member’s out-of-pocket maximum.

### YOU PAY

### UNTIL OUT-OF-POCKET MAXIMUM IS MET

#### PREVENTIVE CARE SERVICES

- **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

#### 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
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HOSPITALIZATION SERVICES

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

• Newborn delivery (private room when determined medically necessary by a participating provider) ........ $500 per day
• 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
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Mail Order (90 day supply)
Preferred generic medications ........................................ $20
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DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA 20% copay

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

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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 SERVICE
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
(Insulin is covered under the prescription benefit) 20% copay

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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. 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, patch contraceptives and diaphragms.
- Prenatal Prescription vitamins or vitamins in conjunction with fluoride.
- Pediatric asthma supplies and devices.
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.

“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 presence of a drug listed 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 you consult your tax of financial advisor to determine whether HSAs and this high-deductible health care plan are a good choice for you.
Section 5

Prescription Rider Plans
(optional prescription riders to the Premier and Advantage plans; elected by the Employer)

- Prescription A
- Prescription E
- Prescription H
- Prescription W

All plans offer:

**Prescription benefits**
Administered by Medco Health Solutions, Inc.
800.903.8664   medcohealth.com

**Three-tier copayment structure:** Preferred generic / Preferred brand name / non-Preferred medications

**Mail Order feature:** 90-day supply for two copayments
Prescription A
COPayment SUMMARY

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 Medications .......................................................... $5
Preferred Brand Name Medications* ............................................. $10
Non-Preferred Medications* .......................................................... $20

Mail Order (up to 90 day supply)
Preferred Generic Medications .......................................................... $10
Preferred Brand Name Medications* ............................................. $20
Non-Preferred Medications* .......................................................... $40

*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.

Prescription copayments do not contribute to the medical annual out-of-pocket maximum.

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the Member will only be responsible to pay the actual cost of the medication.

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 contraceptives and diaphragms.
- Prenatal Prescription vitamins or vitamins in conjunction with fluoride.

DEFINITIONS

“A"Approved Drug Usage” means (1) use for the labeled indications (FDA-approved indications) or (2) use by a Physician for treatment of a life-threatening condition for which the drug has been recognized by the AMA Drug Evaluations, The American Hospital Formulary, the United States Pharmacopoeia, or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

“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 and 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 United States Food and Drug Administration and meets the same standards as a Brand Name medication in all facets: purity, safety, strength and effectiveness.

“Maintenance Medication” is any covered Prescription medications that are to be taken beyond 60 days. Examples include medications for high blood pressure, diabetes, arthritis, some allergy medications and oral contraceptives.

“Participating Pharmacy” is a pharmacy under contract with WHA, authorized to dispense covered Prescription medications to members who are entitled under this 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 Generic, Preferred Brand Name or Non-Preferred Brand Name.
Drugs are evaluated regularly to determine the additions and possible deletions of medications, to ensure rational and cost effective use of pharmaceutical agents through the P&T Committee, which meets every other month. Physicians may request that the P&T Committee consider adding specific medications to the PDL. The Committee reviews all medications for the efficacy, quality, safety, similar alternatives, and cost of the drug in determining the inclusion in the PDL.

“Prescription Medication” is a drug which has been approved by the United States Food and Drug Administration 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 which is issued by the attending physician within the scope of his or her professional license.

“Three-Tier Copay Plan” means Generic medications listed on the PDL are covered at the lowest copayment. 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 appropriate use based on criteria set by the WHA P&T Committee. Please note the presence of a drug listed 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 1.888.563.2250 or view the document on the Web site: 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 equivalent Generic medication for the prescribed Brand Name medication (Preferred or Non-Preferred) unless your physician writes “do not substitute,” or “prescribe as written,” or it is included in the list of narrow therapeutic drugs for which there is more information below. A Brand Name drug will be provided if there is not a Generic equivalent available. Certain drugs that currently have potential equivalency issues are called “Narrow Therapeutic Index” (NTI) drugs. In these cases, you will be provided the Brand Name drug as written by your 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 at 1.888.563.2250.

b. Some Prescription medications may require prior authorization by WHA. For clarification, please contact WHA Member Services at 1.888.563.2250. Prior authorization requests for routine/non-urgent requests are processed within 24 hours of receipt if all applicable information is included with the request. For urgent requests, coverage determinations are made within 1–4 hours of receipt of the request. An initial prior authorization form may be faxed to the reviewer and requests may also be made by telephone with all applicable information taken by the pharmacist. For a prior authorization request after business hours, weekends or holidays in an urgent or emergency situation, WHA has arranged for the dispensing of an emergency short supply of the medication.

c. Covered Prescription medications other then maintenance medications (see item d) are normally limited to a 30-day supply.

d. Covered Prescription medications that are to be taken beyond 60 days are considered maintenance medications. Maintenance medications may be obtained through WHA’s 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) doses per month for a 30-day period and is subject to a 50% copay.

h. Medications that are experimental, investigational, are not FDA-approved or are not used for Approved Drug Usage (i.e., for the condition or indication for which they are prescribed) are excluded, except life-threatening or seriously debilitating conditions and cancer clinical trials as described in the Combined Evidence of Coverage, under the section titled “Appeal for Investigational/Experimental Treatment”.

i. Prescriptions written by dentists are excluded.

j. Drugs required for foreign travel are excluded, unless they are prior authorized for medical necessity.

k. Cosmetic products, health or beauty aids, dietary or nutritional aids, and all products to retard or reverse the aging of the skin, whether Prescription or non-Prescription, are excluded.

l. Drugs used for weight loss, including appetite suppressants, dietary or nutritional aids are excluded, unless they are prior authorized for medical necessity.

m. Contraceptive devices, including IUD’s, and implantable contraceptives such as Norplant, are not covered under the pharmacy benefit; they are covered under the medical benefit as described in the Combined Evidence of Coverage.

n. Medication for injection or implantation (except insulin and other medications as determined by WHA) are covered under the medical benefit as described in the Combined Evidence of Coverage, under the section titled “Outpatient Services” and “Diabetes supplies, equipment and services”.

o. Pharmacies dispensing covered Prescription medications to Members pursuant to the Agreement and this pharmacy 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.

p. 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.

q. Medications for the treatment of Infertility are excluded, unless added by the employer as supplemental benefit coverage and an appropriate endorsement is attached to the Combined Evidence of Coverage and Disclosure Form.

r. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride).

PRESCRIPTION CLAIM REIMBURSEMENT
If you have to pay for a covered Prescription Medication as described in this Copayment Summary, submit your original receipt along with a copy of your member identification card, address, a daytime telephone number, and the reason for the reimbursement request directly to WHA within 60 days of purchase. No claim will be considered if submitted beyond 12 months from the date of purchase. Please direct all reimbursement requests to:

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Attn. Member Services Department
## Prescription Copays for Covered Medications

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

<table>
<thead>
<tr>
<th>Tier</th>
<th>Example Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-In Pharmacy (up to 30 day supply)</td>
<td>Preferred Generic Medications</td>
<td>$10</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Name Medications</td>
<td>$20</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Medications</td>
<td>$30</td>
</tr>
<tr>
<td>Mail Order (up to 90 day supply)</td>
<td>Preferred Generic Medications</td>
<td>$20</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Name Medications</td>
<td>$40</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Medications</td>
<td>$60</td>
</tr>
</tbody>
</table>

### Definitions

- **Approved Drug Usage** means (1) use for the labeled indications (FDA-approved indications) or (2) use by a Physician for treatment of a life-threatening condition for which the drug has been recognized by the AMA Drug Evaluations, The American Hospital Formulary, the United States Pharmacopoeia, or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

- **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 and 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 United States Food and Drug Administration and meets the same standards as a Brand Name medication in all facets: purity, safety, strength and effectiveness.

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

- **Participating Pharmacy** is a pharmacy under contract with WHA, authorized to dispense covered Prescription medications to members who are entitled under this 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 Generic, Preferred Brand Name or Non-Preferred Brand Name.
Drugs are evaluated regularly to determine the additions and possible deletions of medications, to ensure rational and cost effective use of pharmaceutical agents through the P&T Committee, which meets every other month. Physicians may request that the P&T Committee consider adding specific medications to the PDL. The Committee reviews all medications for the efficacy, quality, safety, similar alternatives, and cost of the drug in determining the inclusion in the PDL.

“Prescription Medication” is a drug which has been approved by the United States Food and Drug Administration 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 which is issued by the attending physician within the scope of his or her professional license.

“Three-Tier Copay Plan” means Generic medications listed on the PDL are covered at the lowest copayment. 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 appropriate use based on criteria set by the WHA P&T Committee. Please note the presence of a drug listed 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 1.888.563.2250 or view the document on the Web site: 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 equivalent Generic medication for the prescribed Brand Name medication (Preferred or Non-Preferred) unless your physician writes “do not substitute,” or “prescribe as written,” or it is included in the list of narrow therapeutic drugs for which there is more information below. A Brand Name drug will be provided if there is not a Generic equivalent available. Certain drugs that currently have potential equvalency issues are called “Narrow Therapeutic Index” (NTI) drugs. In these cases, you will be provided the Brand Name drug as written by your 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 at 1.888.563.2250.

b. Some Prescription medications may require prior authorization by WHA. For clarification, please contact WHA Member Services at 1.888.563.2250. Prior authorization requests for routine/non-urgent requests are processed within 24 hours of receipt if all applicable information is included with the request. For urgent requests, coverage determinations are made within 1-4 hours of receipt of the request. An initial prior authorization form may be faxed to the reviewer and requests may also be made by telephone with all applicable information taken by the pharmacist. For a prior authorization request after business hours, weekends or holidays in an urgent or emergency situation, WHA has arranged for the dispensing of an emergency short supply of the medication.

c. Covered Prescription medications other than maintenance medications (see item d) are normally limited to a 30-day supply.

d. Covered Prescription medications that are to be taken beyond 60 days are considered maintenance medications. Maintenance medications may be obtained through WHA’s 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) doses per month for a 30-day period and is subject to a 50% copay.

h. Medications that are experimental, investigational, are not FDA-approved or are not used for Approved Drug Usage (i.e., for the condition or indication for which they are prescribed) are excluded, except life-threatening or seriously debilitating conditions and cancer clinical trials as described in the Combined Evidence of Coverage, under the section titled “Appeal for Investigational/Experimental Treatment”.

i. Prescriptions written by dentists are excluded.

j. Drugs required for foreign travel are excluded, unless they are prior authorized for medical necessity.

k. Cosmetic products, health or beauty aids, dietary or nutritional aids, and all products to retard or reverse the aging of the skin, whether Prescription or non-Prescription, are excluded.

l. Drugs used for weight loss, including appetite suppressants, dietary or nutritional aids are excluded, unless they are prior authorized for medical necessity.

m. Contraceptive devices, including IUD’s, and implantable contraceptives such as Norplant, are not covered under the pharmacy benefit; they are covered under the medical benefit as described in the Combined Evidence of Coverage.

n. Medication for injection or implantation (except insulin and other medications as determined by WHA) are covered under the medical benefit as described in the Combined Evidence of Coverage.

o. Pharmacies dispensing covered Prescription medications to Members pursuant to the Agreement and this pharmacy 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.

p. 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.

q. Medications for the treatment of infertility are excluded, unless added by the employer as supplemental benefit coverage and an appropriate endorsement is attached to the Combined Evidence of Coverage and Disclosure Form.

r. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride).

PRESCRIPTION CLAIM REIMBURSEMENT
If you have to pay for a covered Prescription Medication as described in this Copayment Summary, submit your original receipt along with a copy of your member identification card, address, a daytime telephone number, and the reason for the reimbursement request directly to WHA within 60 days of purchase. No claim will be considered if submitted beyond 12 months from the date of purchase. Please direct all reimbursement requests to:

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Attn. Member Services Department
Prescription H
COPAYMENT SUMMARY

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 Medications. .................................................. $10
Preferred Brand Name Medications* ....................................... $30
Non-Preferred Medications* ................................................... $50

Mail Order (up to 90 day supply)
Preferred Generic Medications. .................................................. $20
Preferred Brand Name Medications* ....................................... $60
Non-Preferred Medications* ................................................... $100

*(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.

Prescription copayments do not contribute to the medical annual out-of-pocket maximum.

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the member will only be responsible to pay the actual cost of the medication.

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 contraceptives and diaphragms.
- Prenatal Prescription vitamins or vitamins in conjunction with fluoride.

DEFINITIONS

“Approved Drug Usage” means (1) use for the labeled indications (FDA-approved indications) or (2) use by a Physician for treatment of a life-threatening condition for which the drug has been recognized by the AMA Drug Evaluations, The American Hospital Formulary, the United States Pharmacopoeia, or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

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“Prescription Medication” is a drug which has been approved by the United States Food and Drug Administration 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 which is issued by the attending physician within the scope of his or her professional license.

“Three-Tier Copay Plan” means Generic medications listed on the PDL are covered at the lowest copayment. 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 appropriate use based on criteria set by the WHA P&T Committee. Please note the presence of a drug listed 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 1.888.563.2250 or view the document on the Web site: 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 equivalent Generic medication for the prescribed Brand Name medication (Preferred or Non-Preferred) unless your physician writes “do not substitute,” or “prescribe as written,” or it is included in the list of narrow therapeutic drugs for which there is more information below. A Brand Name drug will be provided if there is not a Generic equivalent available. Certain drugs that currently have potential equivalency issues are called “Narrow Therapeutic Index” (NTI) drugs. In these cases, you will be provided the Brand Name drug as written by your 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 at 1.888.563.2250.

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c. Covered Prescription medications other then maintenance medications (see item d) are normally limited to a 30-day supply.

d. Covered Prescription medications that are to be taken beyond 60 days are considered maintenance medications. Maintenance medications may be obtained through WHA’s 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) doses per month for a 30-day period and is subject to a 50% copay.

h. Medications that are experimental, investigational, are not FDA-approved or are not used for approved Drug Usage (i.e., for the condition or indication for which they are prescribed) are excluded, except life-threatening or seriously debilitating conditions and cancer clinical trials as described in the Combined Evidence of Coverage, under the section titled “Appeal for Investigational/Experimental Treatment”.

i. Prescriptions written by dentists are excluded.

j. Drugs required for foreign travel are excluded, unless they are prior authorized for medical necessity.

k. Cosmetic products, health or beauty aids, dietary or nutritional aids, and all products to retard or reverse the aging of the skin, whether prescription or non-Prescription, are excluded.

l. Drugs used for weight loss, including appetite suppressants, dietary or nutritional aids are excluded, unless they are prior authorized for medical necessity.

m. Contraceptive devices, including IUD’s, and implantable contraceptives such as Norplant, are not covered under the pharmacy benefit; they are covered under the medical benefit as described in the Combined Evidence of Coverage.

n. Medication for injection or implantation (except insulin and other medications as determined by WHA) are covered under the medical benefit as described in the Combined Evidence of Coverage, under the section titled “Outpatient Services” and “Diabetes supplies, equipment and services”.

o. Pharmacies dispensing covered Prescription medications to Members pursuant to the Agreement and this pharmacy 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.

p. 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.

q. Medications for the treatment of infertility are excluded, unless added by the employer as supplemental benefit coverage and an appropriate endorsement is attached to the Combined Evidence of Coverage and Disclosure Form.

r. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride).

PRESCRIPTION CLAIM REIMBURSEMENT

If you have to pay for a covered Prescription Medication as described in this Copayment Summary, submit your original receipt along with a copy of your member identification card, address, a daytime telephone number, and the reason for the reimbursement request directly to WHA within 60 days of purchase. No claim will be considered if submitted beyond 12 months from the date of purchase. Please direct all reimbursement requests to:

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Attn. Member Services Department
Prescription W
COPAYMENT SUMMARY

DEeductible
In any calendar year we will not cover Preferred and Non-Preferred Brand Name medication until member meets the following deductible ............................................... $150 per member during that calendar year

Prescription Copayments for Covered Medications

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>Covered Medications</th>
<th>Member Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-In Pharmacy (up to 30 day supply)</td>
<td>Preferred Generic Medications. ............................................................................. $10</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand Name Medications*</td>
<td>$30 after deductible</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Medications*</td>
<td>$50 after deductible</td>
<td></td>
</tr>
<tr>
<td>Mail Order (up to 90 day supply)</td>
<td>Preferred Generic Medications. ............................................................................. $20</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand Name Medications*</td>
<td>$60 after deductible</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Medications*</td>
<td>$100 after deductible</td>
<td></td>
</tr>
</tbody>
</table>

* 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.

Prescription copayments do not contribute to the medical annual out-of-pocket maximum.

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the Member will only be responsible to pay the actual cost of the medication.

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 contraceptives and diaphragms.
- Prenatal Prescription vitamins or vitamins in conjunction with fluoride.

Definitions

“Approved Drug Usage” means (1) use for the labeled indications (FDA-approved indications) or (2) use by a Physician for treatment of a life-threatening condition for which the drug has been recognized by the AMA Drug Evaluations, The American Hospital Formulary, the United States Pharmacopoeia, or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

“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 and 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 United States Food and Drug Administration and meets the same standards as a Brand Name medication in all facets: purity, safety, strength and effectiveness.

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

**COPAYMENT SUMMARY**

“Participating Pharmacy” is a pharmacy under contract with WHA, authorized to dispense covered Prescription medications to members who are entitled under this 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 Generic, Preferred Brand Name or Non-Preferred Brand Name.

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

“Prescription Medication” is a drug which has been approved by the United States Food and Drug Administration 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 which is issued by the attending physician within the scope of his or her professional license.

“Three-Tier Copay Plan” means Generic medications listed on the PDL are covered at the lowest copayment. 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 appropriate use based on criteria set by the WHA P&T Committee. Please note the presence of a drug listed 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 1.888.563.2250 or view the document on the Web site: 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 equivalent Generic medication for the prescribed Brand Name medication (Preferred or Non-Preferred) unless your physician writes “do not substitute,” or “prescribe as written,” or it is included in the list of narrow therapeutic drugs for which there is more information below. A Brand Name drug will be provided if there is not a Generic equivalent available. Certain drugs that currently have potential equivalency issues are called “Narrow Therapeutic Index” (NTI) drugs. In these cases, you will be provided the Brand Name drug as written by your 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 at 1.888.563.2250.

b. Some Prescription medications may require prior authorization by WHA. For clarification, please contact WHA Member Services at 1.888.563.2250. Prior authorization requests for routine/non-urgent requests are processed within 24 hours of receipt if all applicable information is included with the request. For urgent requests, coverage determinations are made within 1–4 hours of receipt of the request. An initial prior authorization form may be faxed to the reviewer and requests may also be made by telephone with all applicable information taken by the pharmacist. For a prior authorization request after business hours, weekends or holidays in an urgent or emergency situation, WHA has arranged for the dispensing of an emergency short supply of the medication.

c. Covered Prescription medications other than maintenance medications (see item d) are normally limited to a 30-day supply.

d. Covered Prescription medications that are to be taken beyond 60 days are considered maintenance medications. Maintenance medications may be obtained through WHA’s 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) doses per month for a 30-day period and is subject to a 50% copay.

h. Medications that are experimental, investigational, are not FDA-approved or are not used for Approved Drug Usage (i.e., for the condition or indication for which they are prescribed) are excluded, except life-threatening or seriously debilitating conditions and cancer clinical trials as described in the Combined Evidence of Coverage, under the section titled “Appeal for Investigational/Experimental Treatment”.

i. Prescriptions written by dentists are excluded.

j. Drugs required for foreign travel are excluded, unless they are prior authorized for medical necessity.

k. Cosmetic products, health or beauty aids, dietary or nutritional aids, and all products to retard or reverse the aging of the skin, whether the prescription or non-prescription, are excluded.

l. Drugs used for weight loss, including appetite suppressants, dietary or nutritional aids are excluded, unless they are prior authorized for medical necessity.

m. Contraceptive devices, including IUD’s, and implantable contraceptives such as Norplant, are not covered under the pharmacy benefit; they are covered under the medical benefit as described in the Combined Evidence of Coverage.

n. Medication for injection or implantation (except insulin and other medications as determined by WHA) are covered under the medical benefit as described in the Combined Evidence of Coverage, under the section titled “Outpatient Services” and “Diabetes supplies, equipment and services”.

o. Pharmacies dispensing covered Prescription medications to Members pursuant to the Agreement and this pharmacy 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.

p. 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.

q. Medications for the treatment of Infertility are excluded, unless added by the employer as supplemental benefit coverage and an appropriate endorsement is attached to the Combined Evidence of Coverage and Disclosure Form.

r. Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride).

**PRESCRIPTION CLAIM REIMBURSEMENT**

If you have to pay for a covered Prescription Medication as described in this Copayment Summary, submit your original receipt along with a copy of your member identification card, address, a daytime telephone number, and the reason for the reimbursement request directly to WHA within 60 days of purchase. No claim will be considered if submitted beyond 12 months from the date of purchase. Please direct all reimbursement requests to:

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Attn. Member Services Department
Additional Information
And
Optional Riders

- Complementary Alternative Medicine (CAM) Benefits – included in Premier and Advantage plans only
- Infertility Rider – available to Employer groups with 20+ full-time employees at an additional cost
- Vision Plans – available to Employer groups with 2+ enrolled employees at an additional cost

Vision plans offer:

**Full Service Plans:** annual examination and materials covered by MESVision

**Eye Wear Only Plans:** materials only covered by MESVision (annual examination under WHA health plans)

Vision plans administered and underwritten by MES Vision
800.877.6372 mesvision.com
Complementary Alternative Medicine (CAM) Benefits

In the United States, 62% of adults are using some form of CAM, which includes provider based therapies such as acupuncture and chiropractic care.

National Center for Complementary and Alternative Medicine
May 2004

ACUPUNCTURE BENEFIT OVERVIEW*

Covers treatment of pain related to acute neuromusculoskeletal conditions such as dysfunction of the neck, back or joints, headaches, carpal tunnel, arthritis, allergies and asthma. Acupuncture services must be authorized.

- $15 copay
- PCP referral is not required to receive covered services
- 20 medically necessary visits per year
- Typically covered acupuncture services include:
  - Evaluation
  - Electroacupuncture
  - Acupressure
  - Manual stimulation
  - Moxibustion
  - Cupping

CHIROPRACTIC BENEFIT OVERVIEW*

Covers treatment of pain related to acute neuromusculoskeletal conditions such as low back pain, sprains and strains, headaches, neck pain, and muscle spasms. Chiropractic services must be authorized.

- $15 copay
- PCP referral is not required to receive covered services
- 20 medically necessary visits per year
- Typically covered chiropractic services include:
  - History
  - Examination
  - Manipulation
  - Conjunctive physiotherapy
  - X-rays

TO LOCATE A PARTICIPATING PRACTITIONER

Visit www.landmarkhealthcare.com or call (800) 638-4557 to locate a participating acupuncturist or chiropractor in your area.

*Refer to the Summary of Benefits and Evidence of Coverage and Disclosure Form for full plan details. Complementary alternative medicine services are administered by Landmark Healthplan of California, Inc.
INFERTILITY SERVICES
Covered Infertility services generally include consultations, examinations, diagnostic services whether performed in a physician’s office or in a hospital or other facility, and medications. All covered Infertility services, including the diagnostic work-up and testing to establish a cause of “Infertility”, require a 50% copayment, which is based on WHA’s contracted charges. All covered Infertility services must receive prior authorization and are subject to the exclusions and limitations set forth in this Copayment Summary.

Copayments for covered Infertility services do not contribute to the annual out-of-pocket maximum of your medical plan with Western Health Advantage.

“Infertility” is defined as a condition of being pre-menopausal with either: (1) the presence of a condition recognized by the physician as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after one year or more of regular sexual relations without contraception.

COVERED SERVICES — 50% COPAYMENT
• Services and supplies for diagnosis and treatment of involuntary infertility;
• Artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime;\(^*\)
• One Gamete Intra-Fallopian Transfer (GIFT) or In Vitro Fertilization per Lifetime;\(^*\)
• Medications for the treatment of Infertility.

Genetic testing and counseling are covered benefits when medically indicated and are not subject to the Infertility Benefit copayments.

*“Lifetime” refers to services obtained during the member’s life, including services provided under any other health insurance or HMO.

EXCLUSIONS AND LIMITATIONS
In addition to exclusions and limitations described under Covered Services, the following apply:
• The member must be diagnosed with “Infertility” as defined in this Copayment Summary.
• Services and supplies to reverse voluntary, surgically induced infertility are excluded.
• All services involved in surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded.
• Frozen embryo transfers and Zygote Intra-Fallopian Transfer (ZIFT) are excluded.
• Intracytoplasmic Sperm Injection (ICSI) is excluded.
• Ova sticks (a self-test for infertility) are excluded.
• Ovum transfer/transplants or uterine lavage as part of infertility diagnosis or treatment is excluded.
• All services related to the sperm donor, including the collection of the sperm, are excluded.
• Sperm storage is excluded.
• Treatment of infertility as a result of previous/prevailing elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts, is excluded.
• Artificial insemination in the absence of a diagnosis of Infertility is excluded.
• Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome) is excluded.
• Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of infertility are excluded.
• Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos are excluded.
• Inoculation of a woman with partner’s white cells is excluded (considered experimental).
• All covered Infertility services must be prior authorized by WHA.
Summary of Vision Benefits
Full Service Plan - $0 Copay

Comprehensive Vision Exam
Lenses
Frame
Contact Lenses

One every 12 months
One every 24 months
One every 24 months
One every 24 months

The Policy provides full coverage for Covered Services when you go to an MESVision Participating Provider. If Covered Services are provided by a non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances:

<table>
<thead>
<tr>
<th>Participating Provider</th>
<th>non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copay</td>
<td>$0</td>
</tr>
<tr>
<td>Covered</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Comprehensive Examination</td>
<td>Covered</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Covered</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>Covered</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>Covered</td>
</tr>
<tr>
<td>Aphakic or Lenticular Lenses</td>
<td>Covered</td>
</tr>
<tr>
<td>Frame</td>
<td>Covered2</td>
</tr>
<tr>
<td>Contact Lenses*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Medically Necessary*</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Cosmetic or Convenience</td>
<td>Up to $100</td>
</tr>
</tbody>
</table>

1. Non-Participating benefits are underwritten by Gerber Life Insurance Company.
2. Participating Providers allow a selection of frames that retail up to $90 with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above $90. If the lenses are 61 millimeters or above, the charge for oversize lenses is your responsibility.
3. This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to $100 toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are Medically Necessary, they are a fully covered benefit. Approval from MES is required. Please refer to your Policy if you require additional information.
4. Medically Necessary contact lenses are defined as contact lenses prescribed following cataract surgery; or when visual acuity cannot be corrected to 20/40 except with the use of contact lenses for certain conditions of keratoconus and anisometropia; or for certain conditions of myopia, hyperopia or astigmatism. Prior approval from MES is required.

* Coverage available every 12 months if there is a change in prescription:
  - A change in prescription of 0.50 diopter or more in both eyes;
  - A shift in astigmatism of 15 degrees; or
  - A difference in vertical prism greater than 1 prism diopter.

A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can check with the Participating Provider, call MESVision, or visit www.mesvision.com. Discounts are also available through TLCVision for conventional and custom LASIK procedures and with the TLCVision Advantage Program.

To find a participating provider, an insured individual can visit www.mesvision.com or call MESVision at (800) 877-6372.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.
TO EASILY OBTAIN SERVICES

• Select a Participating Provider from the MESVision directory or visit www.mesvision.com.
• Make an appointment directly with the provider of your choice and inform them of your coverage.
• Participating Providers will have claim forms available. If you select a non-Participating Provider, claim forms are available at www.mesvision.com, or from your employer.
• At your appointment, you will pay any applicable copayment and optional eyewear costs. If you select a Participating Provider, the provider will submit the claim. If you select a non-Participating Provider, please mail your completed claim form to:

  MESVision
  P.O. Box 25209
  Santa Ana, CA 92799-5209

EXCLUSIONS

Benefits will not be payable under the Policy for expenses incurred for any of the following:

• Any eye examination required by an employer as a condition of employment;
• Any covered services provided by another vision plan;
• Conditions covered by Workers’ Compensation;
• Contact lens insurance or care kits;
• Covered services which began prior to the enrollee’s effective date, or after the benefit has terminated;
• Covered services for which the Insured is not legally obligated to pay;
• Covered services required by any government agency or program, federal, state or subdivision thereof;
• Covered services performed by a close relative or by an individual who ordinarily resides in the enrollee’s home;
• Medical or surgical treatment of the eyes;
• Non-prescription (plano) eyewear;
• Orthoptics, subnormal vision aids or vision training;
• Services that are experimental or investigational in nature;
• Services for treatment directly related to any totally disabling condition, illness or injury.

LIMITATIONS

The following benefits are subject to limitations under the Policy:

• Contact lenses, except as specifically provided;
• Contact lens fitting, except as specifically provided;
• Eyewear when there is no prescription change, except when benefits are otherwise available;
• Lenses or frames which are lost, stolen, or broken will not be replaced, except when benefits are otherwise available;
• Lenses such as no-line (blended type), progressive, beveled, faceted, coated or oversize exceeding the allowance for covered lenses;
• Tints, other than pink or rose #1 or #2, except as specifically provided;
• Two pairs of glasses in lieu of bifocals, unless prescribed.

If you have any questions about the vision benefits, please contact MESVision by mail at P.O. Box 25209; Santa Ana, CA 92799-5209; by phone at (714) 619-4660 or toll-free at (800) 877-6372; or online at www.mesvision.com.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.
Summary of Vision Benefits
Full Service Plan - $10 Copay

Underwritten by:

The Policy provides full coverage for Covered Services when you go to an MESVision Participating Provider. If Covered Services are provided by a non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances:

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Provider</th>
<th>non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copay</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Comprehensive Examination</td>
<td>Covered</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Covered</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>Covered</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>Covered</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Aphakic or Lenticular Lenses</td>
<td>Covered</td>
<td>Up to $125</td>
</tr>
<tr>
<td>Frame</td>
<td>Covered²</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Covered³</td>
<td>Up to $250</td>
</tr>
<tr>
<td>Medical Necess. or Conven.</td>
<td>Up to $100</td>
<td>Up to $100</td>
</tr>
</tbody>
</table>

1. Non-Participating benefits are underwritten by Gerber Life Insurance Company.
2. Participating Providers allow a selection of frames that retail up to $90 with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above $90. If the lenses are 61 millimeters or above, the charge for oversize lenses is your responsibility.
3. This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to $100 toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are Medically Necessary, they are a fully covered benefit. Approval from MES is required. Please refer to your Policy if you require additional information.
4. Medically Necessary contact lenses are defined as contact lenses prescribed following cataract surgery; or when visual acuity cannot be corrected to 20/40 except with the use of contact lenses for certain conditions of keratoconus and anisometropia; or for certain conditions of myopia, hyperopia or astigmatism. Prior approval from MES is required.

* Coverage available every 12 months if there is a change in prescription:
  • A change in prescription of 0.50 diopter or more in both eyes;
  • A shift in astigmatism of 15 degrees; or
  • A difference in vertical prism greater than 1 prism diopter.

A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can check with the Participating Provider, call MESVision, or visit www.mesvision.com. Discounts are also available through TLCVision for conventional and custom LASIK procedures and with the TLCVision Advantage Program.

To find a participating provider, an insured individual can visit www.mesvision.com or call MESVision at (800) 877-6372.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.
TO EASILY OBTAIN SERVICES

- Select a Participating Provider from the MESVision directory or visit www.mesvision.com.
- Make an appointment directly with the provider of your choice and inform them of your coverage.
- Participating Providers will have claim forms available. If you select a non-Participating Provider, claim forms are available at www.mesvision.com, or from your employer.
- At your appointment, you will pay any applicable copayment and optional eyewear costs. If you select a Participating Provider, the provider will submit the claim. If you select a non-Participating Provider, please mail your completed claim form to:

  MESVision
  P.O. Box 25209
  Santa Ana, CA 92799-5209

EXCLUSIONS

Benefits will not be payable under the Policy for expenses incurred for any of the following:

- Any eye examination required by an employer as a condition of employment;
- Any covered services provided by another vision plan;
- Conditions covered by Workers’ Compensation;
- Contact lens insurance or care kits;
- Covered services which began prior to the enrollee’s effective date, or after the benefit has terminated;
- Covered services for which the Insured is not legally obligated to pay;
- Covered services required by any government agency or program, federal, state or subdivision thereof;
- Covered services performed by a close relative or by an individual who ordinarily resides in the enrollee’s home;
- Medical or surgical treatment of the eyes;
- Non-prescription (plano) eyewear;
- Orthoptics, subnormal vision aids or vision training;
- Services that are experimental or investigational in nature;
- Services for treatment directly related to any totally disabling condition, illness or injury.

LIMITATIONS

The following benefits are subject to limitations under the Policy:

- Contact lenses, except as specifically provided;
- Contact lens fitting, except as specifically provided;
- Eyewear when there is no prescription change, except when benefits are otherwise available;
- Lenses or frames which are lost, stolen, or broken will not be replaced, except when benefits are otherwise available;
- Lenses such as no-line (blended type), progressive, beveled, faceted, coated or oversize exceeding the allowance for covered lenses;
- Tints, other than pink or rose #1 or #2, except as specifically provided;
- Two pairs of glasses in lieu of bifocals, unless prescribed.

If you have any questions about the vision benefits, please contact MESVision by mail at P.O. Box 25209; Santa Ana, CA 92799-5209; by phone at (714) 619-4660 or toll-free at (800) 877-6372; or online at www.mesvision.com.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.
Summary of Vision Benefits
Eyewear Only Plan - $0 Copay

As a WHA Member, you must receive your annual eye examination from an ophthalmologist or optometrist listed in the WHA Provider Directory. To receive your eyewear benefits, you may utilize the examining doctor’s dispensary if the examining doctor is an MESVision Participating Provider or any other provider listed in the MESVision directory. Eyewear benefits will be covered as follows:

<table>
<thead>
<tr>
<th>Item</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td>One every 24 months*</td>
</tr>
<tr>
<td>Frame</td>
<td>One every 24 months</td>
</tr>
<tr>
<td>Contact Lenses³</td>
<td>One every 24 months</td>
</tr>
</tbody>
</table>

The Policy provides full coverage for Covered Services when you go to an MESVision Participating Provider. If Covered Services are provided by a non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances:

<table>
<thead>
<tr>
<th>Item</th>
<th>Participating Provider</th>
<th>non-Participating Provider¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copay</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Covered</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>Covered</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>Covered</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Aphakic or Lenticular Lenses</td>
<td>Covered</td>
<td>Up to $125</td>
</tr>
<tr>
<td>Frame</td>
<td>Covered²</td>
<td>Up to $40</td>
</tr>
<tr>
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1. Non-Participating benefits are underwritten by Gerber Life Insurance Company.
2. Participating Providers allow a selection of frames that retail up to $90 with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above $90. If the lenses are 61 millimeters or above, the charge for oversize lenses is your responsibility.
3. This benefit is in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to $100 toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are Medically Necessary, they are a fully covered benefit. Approval from MES is required.
4. Medically Necessary contact lenses are defined as contact lenses prescribed following cataract surgery; or when visual acuity cannot be corrected to 20/40 except with the use of contact lenses for certain conditions of keratoconus and anisometropia; or for certain conditions of myopia, hyperopia or astigmatism. Prior approval from MES is required.

* Coverage available every 12 months if there is a change in prescription:
  • A change in prescription of 0.50 diopter or more in both eyes;
  • A shift in astigmatism of 15 degrees; or
  • A difference in vertical prism greater than 1 prism diopter.

A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can check with the Participating Provider, call MESVision, or visit www.mesvision.com. Discounts are also available through TLCVision for conventional and custom LASIK procedures and with the TLCVision Advantage Program.

To find a participating provider, an insured individual can visit www.mesvision.com or call MESVision at (800) 877-6372.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.

MES EOP-0 03/07
TO EASILY OBTAIN SERVICES

- Select a Participating Provider from the MESVision directory or visit www.mesvision.com.
- Make an appointment directly with the provider of your choice and inform them of your coverage.
- Participating Providers will have claim forms available. If you select a non-Participating Provider, claim forms are available at www.mesvision.com, or from your employer.
- At your appointment, you will pay any applicable copayment and optional eyewear costs. If you select a Participating Provider, the provider will submit the claim. If you select a non-Participating Provider, please mail your completed claim form to:

  
  
  MESVision
  P.O. Box 25209
  Santa Ana, CA 92799-5209

EXCLUSIONS

Benefits will not be payable under the Policy for expenses incurred for any of the following:

- Any eye examination required by an employer as a condition of employment;
- Any covered services provided by another vision plan;
- Conditions covered by Workers’ Compensation;
- Contact lens insurance or care kits;
- Covered services which began prior to the enrollee’s effective date, or after the benefit has terminated;
- Covered services for which the Insured is not legally obligated to pay;
- Covered services required by any government agency or program, federal, state or subdivision thereof;
- Covered services performed by a close relative or by an individual who ordinarily resides in the enrollee’s home;
- Medical or surgical treatment of the eyes;
- Non-prescription (plano) eyewear;
- Orthoptics, subnormal vision aids or vision training;
- Services that are experimental or investigational in nature;
- Services for treatment directly related to any totally disabling condition, illness or injury.

LIMITATIONS

The following benefits are subject to limitations under the Policy:

- Contact lenses, except as specifically provided;
- Contact lens fitting, except as specifically provided;
- Eyewear when there is no prescription change, except when benefits are otherwise available;
- Lenses or frames which are lost, stolen, or broken will not be replaced, except when benefits are otherwise available;
- Lenses such as no-line (blended type), progressive, beveled, faceted, coated or oversize exceeding the allowance for covered lenses;
- Tints, other than pink or rose #1 or #2, except as specifically provided;
- Two pairs of glasses in lieu of bifocals, unless prescribed.

If you have any questions about the vision benefits, please contact MESVision by mail at P.O. Box 25209; Santa Ana, CA 92799-5209; by phone at (714) 619-4660 or toll-free at (800) 877-6372; or online at www.mesvision.com.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.
Summary of Vision Benefits
Eyewear Only Plan - $10 Copay

As a WHA Member, you must receive your annual eye examination from an ophthalmologist or optometrist listed in the WHA Provider Directory. To receive your eyewear benefits, you may utilize the examining doctor’s dispensary if the examining doctor is an MESVision Participating Provider or any other provider listed in the MESVision directory. Eyewear benefits will be covered as follows:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td>One every 24 months*</td>
</tr>
<tr>
<td>Frame</td>
<td>One every 24 months</td>
</tr>
<tr>
<td>Contact Lenses³</td>
<td>One every 24 months</td>
</tr>
</tbody>
</table>

The Policy provides full coverage for Covered Services when you go to an MESVision Participating Provider. If Covered Services are provided by a non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Participating Provider</th>
<th>non-Participating Provider¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copay</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Covered</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>Covered</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>Covered</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Aphakic or Lenticular Lenses</td>
<td>Covered</td>
<td>Up to $125</td>
</tr>
<tr>
<td>Frame</td>
<td>Covered²</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Contact Lenses³</td>
<td>Medically Necessary⁴</td>
<td>Up to $250</td>
</tr>
<tr>
<td>Cosmetic or Convenience</td>
<td>Up to $100</td>
<td>Up to $100</td>
</tr>
</tbody>
</table>

1. Non-Participating benefits are underwritten by Gerber Life Insurance Company.
2. Participating Providers allow a selection of frames that retail up to $90 with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above $90. If the lenses are 61 millimeters or above, the charge for oversize lenses is your responsibility.
3. This benefit is in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to $100 toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are Medically Necessary, they are a fully covered benefit. Approval from MES is required.
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* Coverage available every 12 months if there is a change in prescription:
  - A change in prescription of 0.50 diopter or more in both eyes;
  - A shift in astigmatism of 15 degrees; or
  - A difference in vertical prism greater than 1 prism diopter.

A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can check with the Participating Provider, call MESVision, or visit www.mesvision.com. Discounts are also available through TLCVision for conventional and custom LASIK procedures and with the TLCVision Advantage Program.

To find a participating provider, an insured individual can visit www.mesvision.com or call MESVision at (800) 877-6372.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.
TO EASILY OBTAIN SERVICES

- Select a Participating Provider from the MESVision directory or visit www.mesvision.com.
- Make an appointment directly with the provider of your choice and inform them of your coverage.
- Participating Providers will have claim forms available. If you select a non-Participating Provider, claim forms are available at www.mesvision.com, or from your employer.
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  MESVision
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  Santa Ana, CA 92799-5209

EXCLUSIONS
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- Covered services for which the Insured is not legally obligated to pay;
- Covered services required by any government agency or program, federal, state or subdivision thereof;
- Covered services performed by a close relative or by an individual who ordinarily resides in the enrollee’s home;
- Medical or surgical treatment of the eyes;
- Non-prescription (plano) eyewear;
- Orthoptics, subnormal vision aids or vision training;
- Services that are experimental or investigational in nature;
- Services for treatment directly related to any totally disabling condition, illness or injury.

LIMITATIONS
The following benefits are subject to limitations under the Policy:

- Contact lenses, except as specifically provided;
- Contact lens fitting, except as specifically provided;
- Eyewear when there is no prescription change, except when benefits are otherwise available;
- Lenses or frames which are lost, stolen, or broken will not be replaced, except when benefits are otherwise available;
- Lenses such as no-line (blended type), progressive, beveled, faceted, coated or oversize exceeding the allowance for covered lenses;
- Tints, other than pink or rose #1 or #2, except as specifically provided;
- Two pairs of glasses in lieu of bifocals, unless prescribed.

If you have any questions about the vision benefits, please contact MESVision by mail at P.O. Box 25209; Santa Ana, CA 92799-5209; by phone at (714) 619-4660 or toll-free at (800) 877-6372; or online at www.mesvision.com.

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.
CalChoice Plans
(available to small groups only, 2-50 employees)

- CalChoice 10
- CalChoice 25
- CalChoice 40

All plans include:

**Behavioral Health Services**: covering Mental Health, Severe Mental Illness and Substance Abuse benefits
  Covered through Magellan Behavioral Health, Inc.
  800.424.1778 magellanhealth.com

**Prescription benefits**
  Administered by Medco Health Solutions, Inc.
  800.903.8664 medcohealth.com

**Infertility benefits**

Note:

CalChoice plans are available to small businesses through the single party administrator,
CaliforniaChoice Benefits Administrator
  800.558.8003 calchoice.com
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

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible amount</td>
<td>None</td>
</tr>
</tbody>
</table>

### Annual Out-of-Pocket Maximum

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

The maximum out-of-pocket expense for Members per calendar year is limited to:

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
</tr>
</tbody>
</table>

### Professional Services

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits for adult and pediatric care</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Well-baby care, birth up to two years</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Maternity care, after the initial diagnosis, pre and post-natal visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Immunizations, adult and pediatric</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Periodic physical examinations</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Office visits for consultation or care by a non-primary provider</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Eye and hearing examinations</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Family planning services</td>
<td>$10 per visit</td>
</tr>
</tbody>
</table>

### Outpatient Services

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery (performed in office setting)</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Outpatient surgery (facility)</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Laboratory, X-ray, electrocardiograms and all other tests</td>
<td>Covered in full</td>
</tr>
<tr>
<td>MRI, CT and PER scans</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Therapeutic injections, including allergy shots</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>All generally accepted cancer screening tests</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

### Hospitalization Services

<table>
<thead>
<tr>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:</td>
<td>$300 per admission</td>
</tr>
<tr>
<td>▪ Newborn delivery (private room when determined medically necessary by a participating provider)</td>
<td>$300 per admission</td>
</tr>
<tr>
<td>▪ Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborn babies</td>
<td>Covered in full</td>
</tr>
<tr>
<td>▪ Blood transfusion services</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Professional inpatient services, including:</td>
<td>Covered in full</td>
</tr>
<tr>
<td>▪ Physicians’ services, including surgeons, anesthesiologists and consultants</td>
<td>Covered in full</td>
</tr>
<tr>
<td>▪ Private-duty nurse when prescribed by a participating physician</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>
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 ......................................................... $10 per visit
Urgent care center ....................................................... $10 per visit
Hospital emergency room (waived if admitted) .......................................................... $50 per visit
Ambulance service as medically necessary or in a life-threatening emergency (including 911) ............... $50 per trip

PRESCRIPTION COVERAGE

Walk-In pharmacy (30 day supply)
Preferred generic / Preferred brand name / Non-Preferred medications ........................................ $10/$20/$35*
Infertility Drugs limited to a $1,500 lifetime maximum

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA ................................................................. 10% to annual maximum of $2,500*

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 ...................................... $30 per visit
Inpatient mental health ........................................................................ Not Covered
Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility .................... $300 per admission

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) ................... $10 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) ................ $300 per admission

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 ................................................. $300 per admission
Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:

Outpatient rehabilitation ........................................................................................................ $10 per visit
Inpatient rehabilitation ........................................................................................................... $300 per admission
Home self injectables, up to $100 maximum copay per 30 day supply (Insulin is covered under the prescription benefit) ... $20% copay*
Infertility evaluation and treatment (except in vitro fertilization) .................................................. 50% of allowed charges

*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.
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

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

The maximum out-of-pocket expense for Members per calendar year is limited to:

- **Individual** ........................................ $2,500
- **Family** ............................................... $5,000
- **Lifetime maximum** ................................ None

### PROFESSIONAL SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th><strong>YOU PAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits for adult and pediatric care</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Well-baby care, birth up to two years</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Maternity care, after the initial diagnosis, pre and post-natal visits</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Immunizations, adult and pediatric</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Periodic physical examinations</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Office visits for consultation or care by a non-primary provider when referred by your primary care physician</td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>$25 per visit</td>
</tr>
<tr>
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<td>$25 per visit</td>
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</tr>
</tbody>
</table>

### OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th><strong>YOU PAY</strong></th>
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</thead>
<tbody>
<tr>
<td>Outpatient surgery (performed in office setting)</td>
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</table>

### HOSPITALIZATION SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th><strong>YOU PAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:</td>
<td>$500 per day to $1,000 maximum per admission</td>
</tr>
</tbody>
</table>

- 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: $25 per visit
- Urgent care center: $25 per visit
- Hospital emergency room (waived if admitted): $100 per visit
- Ambulance service as medically necessary or in a life-threatening emergency (including 911): $50 per trip

**PRESCRIPTION COVERAGE**

- Walk-In Pharmacy (30 day supply)
  - Preferred generic / Preferred brand name / Non-Preferred medications: $15/$25/$40*
- Infertility Drugs limited to a $1,500 lifetime maximum

**DURABLE MEDICAL EQUIPMENT**

- Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 30% to annual maximum of $2,500*

**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: Not Covered
- Inpatient chemical dependency: Short-term inpatient detoxification only, at a WHA acute care facility: $500 per day to $1,000 maximum per admission

**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): $25 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 to $1,000 maximum per admission

**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: $30 per visit

**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 to $1,000 maximum per admission
- Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:
  - Outpatient rehabilitation: $25 per visit
  - Inpatient rehabilitation: $500 per day to $1,000 maximum per admission
- Home self injectables, up to $100 maximum copay per 30 day supply (Insulin is covered under the prescription benefit): 20% copay*
- Infertility evaluation and treatment (except in vitro fertilization): 50% of allowed charges

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<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible amount</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
</tr>
</tbody>
</table>

### PROFESSIONAL SERVICES

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</tr>
<tr>
<td>Eye and hearing examinations</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Family planning services</td>
<td>$40 per visit</td>
</tr>
</tbody>
</table>

### OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery (performed in office setting)</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Outpatient surgery (facility)</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Laboratory, X-ray, electrocardiograms and all other tests</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>MRI, CT and PER scans</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Therapeutic injections, including allergy shots</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>All generally accepted cancer screening tests</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

### HOSPITALIZATION SERVICES

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:</td>
<td>$500 per day</td>
</tr>
<tr>
<td>Newborn delivery (private room when determined medically necessary by a participating provider)</td>
<td>$500 per day</td>
</tr>
<tr>
<td>• Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy and nursery care for newborn babies</td>
<td>$500 per day</td>
</tr>
<tr>
<td>• Blood transfusion services</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Professional inpatient services, including:</td>
<td>Covered in full</td>
</tr>
<tr>
<td>• Physicians’ services, including surgeons, anesthesiologists and consultants</td>
<td>Covered in full</td>
</tr>
<tr>
<td>• Private-duty nurse when prescribed by a participating physician</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>
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: $40 per visit
- Hospital emergency room (waived if admitted): $250 per visit
- Ambulance service as medically necessary or in a life-threatening emergency (including 911): $200 per trip

PRESCRIPTION COVERAGE

- Walk-In pharmacy (30 day supply):
  - Preferred generic / Preferred brand name / Non-Preferred medications: $20/$35/$50*
- Infertility Drugs limited to a $1,500 lifetime maximum

DURABLE MEDICAL EQUIPMENT

- Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA: 50% to annual maximum of $2,500*

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: $50 per visit
  - Inpatient mental health: Not Covered
  - 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

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: $50 per visit

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 (Insulin is covered under the prescription benefit): 20% copay*
- Infertility evaluation and treatment (except in vitro fertilization): 50% of allowed charges

*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.
Exclusions & Limitations

The following are general exclusions and limitations to the WHA plans. Please refer to the applicable Copayment Summary and/or Combined Evidence of Coverage and Disclosure Form (EOC) for more specific information.
Section 8

Exclusions and Limitations

Exclusions

For a detailed description of the exclusions and limitations of any health plan, please refer to the applicable Combined Evidence of Coverage and Disclosure Form (EOC/DF).

The following Services and Supplies are excluded from coverage and are not covered by WHA:

1. Any services or supplies obtained before the Member’s effective date of coverage.
2. Services and supplies which are not Medically Necessary.
3. Non-emergent services and supplies rendered by non-Participating Providers without written referral by the Member’s PCP.
4. Experimental medical or surgical procedures, services or supplies.
5. Long term care benefits including skilled nursing care and respite care, except Medically Necessary Covered Services as specifically described in the EOC/DF.
6. Cosmetic services and supplies, except as specifically described in the EOC/DF.
7. Rehabilitation Therapy Services, physical, speech and occupational therapy, except as specifically described in the EOC/DF.
8. Penile Prostheses unless prescribed by a Participating Physician and determined to be Medically Necessary.
9. Non-emergent medical transport or ambulance care inside or outside the Service Area, except with Prior Authorization.
10. Vision therapy, surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses (except for intraocular lenses in connection with cataract removal), eyeglasses and contact lenses.
11. Hearing aids and batteries.
12. Services or supplies in connection with the storage of body parts, fluids or tissues, except for autologous blood.
13. Dental care, except as specifically described in the EOC/DF.
14. Any services or supplies provided by a person who lives in the Member’s home, or by an immediate relative of the Member.
15. Personal comfort or convenience items (e.g., television, radio), home or automobile modifications, or improvements (e.g., chair lifts, purifiers).
16. Vitamins, except prenatal prescription vitamins or vitamins in conjunction with fluoride.
17. Outpatient prescription medications, unless added by the Employer as supplemental pharmacy benefit coverage and an appropriate endorsement is attached to the EOC/DF.
18. Routine foot care (e.g., treatment of or to the feet for corns, or calluses), except when Medically Necessary. Orthotic Devices for routine foot care are also excluded. This exclusion does not apply to special footwear required as a result of foot disfigurement caused by diabetes.
19. Acupressure, biofeedback, sex therapy, dance therapy and recreational therapy.
20. All immunizations required by an employer as a condition of employment.
21. Conception by artificial means and all services related to conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), donor semen or eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).
22. Infertility Services, which are services related to the diagnosis and treatment of infertility, unless Infertility Benefit Rider has been purchased.
23. Services and supplies in connection with the reversal of voluntary sterilization.
24. Sex Change (Transsexual) surgery or treatment related to changing a Member’s physical characteristics to those of the opposite sex.
25. Surrogacy, except as specifically described in the EOC/DF.


27. Custodial care or services and supplies furnished by an institution which is primarily a place for rest and provides primarily non-nursing supervision of the patient, except as specifically described in the EOC/DF.

28. Non-prescription weight loss aids and programs and non-participating provider programs.

29. Smoking cessation products and programs.

30. Repair and replacement of DME, Orthotics or Prosthetics, when necessitated by the Member's abuse, misuse or loss. Any device not medical in nature (e.g., exercise equipment, whirlpool, spa), more than one device for the same body part, or more than one piece of equipment that serves the same function.

31. Food supplements or infant formulas, except in the treatment of PKU.

32. Over-the-counter supplies or equipment that may be obtained without a prescription, except for diabetes or pediatric asthma supplies or equipment.

33. Services and supplies that are in connection with the donation of organs where the recipient is not a member of WHA.

34. Court ordered health care services and supplies when not Medically Necessary.

35. Travel expenses including room and board even if the purpose is to obtain a Covered Service.

36. Expenses incurred for the purpose of obtaining copies of the medical records if requested by the Member for personal use.

37. Weight control surgery or procedures including, without limitation, gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction, HCG injections and any Experimental Procedures for the treatment of obesity. However, Medically Necessary services, as determined by WHA, for the treatment of morbid obesity with a Prior Authorization is a covered benefit.

38. Testing for the sole purpose of determining paternity.

39. Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high risk pregnancy or when medically indicated.

40. Diagnosis and treatment for personal growth and/or development, personality reorganization or in conjunction with professional certification.

41. Marriage counseling, except for the treatment of a Mental Health Disorder/Condition.

42. Diagnosis and treatment of developmental disorders as specifically described in the EOC/DF.

43. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other education services.

44. Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to parole or probation proceedings).

45. Psychological testing, except when conducted for the purpose of diagnosis of a Mental Health Disorder/Condition or a condition related to drug or alcohol dependence.

46. Mental health treatment of obesity or weight reduction (except in connection with anorexia nervosa or bulimia), including supplies.

47. Stress management therapy.

48. Aversion therapy.

49. Mental health treatment of pain, except for Medically Necessary treatment of pain with psychological or psychosomatic origins.

50. Treatment of idiopathic short stature (short stature not due to a medical condition).
Limitations

All benefits for Covered Services are provided in connection with determining Medical Necessity. The services and supplies for diagnosing and treating any disease, illness or injury must be in accordance with professionally recognized standards of practice.

1. Services and supplies rendered by non-Participating Providers are covered for Urgent Care and Emergency Care only or when a Participating Provider is not available through the Participating Provider panel and has been authorized in advance.

2. Physical, speech, and occupational therapy and cardiac and pulmonary rehabilitation are limited to short-term rehabilitation services, except when additional care is Medically Necessary.

3. Physical exams, and/or laboratory, x-ray or other diagnostic tests ordered in conjunction with a physical exam will not be a covered benefit if the purpose of the test is exclusively to fulfill an employment, licensing, sports, or school related requirement.

4. If services or supplies are received while a Member is entitled to benefits from another health plan, or for which a Member is entitled to collect damages due to a third party’s liability, including Workers’ Compensation, a Member is required to assist in the assignment, liens and recovery of any WHA or HAI-CA expense. WHA may file a lien on any proceeds received by a Member for any expense incurred by WHA or HAI-CA. Members not legally required to be covered by Workers’ Compensation benefits are eligible for 24-hour coverage under WHA.

5. WHA will not be held liable for the lack of available services in the event of a major disaster, epidemic, war, riot or other like circumstance beyond the control of WHA which renders a Participating Provider unable to provide services. Refer to the EOC/DF for additional information.

6. For Covered Services, WHA reserves the right to coordinate your care in a cost effective and efficient manner.

7. Private hospital rooms and/or private duty nursing in connection with treatment of Mental Health Disorders/Conditions or conditions related to drug or alcohol dependence are not covered benefits, unless determined to be Medically Necessary and authorized by HAI-CA.