University of California 106A

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

Western Health Advantage

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLE	COST TO MEMBER
Deductible amount	None

ANNUAL OUT-OF-POCKET MAXIMUM	COST TO MEMBER
The maximum out-of-pocket expense for a Member per calendar year is limited to either the Individual amount or Family amount, whichever is met first:	
Individual	$1,000
Family	$3,000
All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.	
Lifetime maximum	None

PROFESSIONAL SERVICES	COST TO MEMBER
Office visits for adult and pediatric care.	$15 per visit
Well-baby care, birth up to two years	None
Maternity care, after the initial diagnosis, pre and post-natal visits	None
Office administered preventive inoculations	None
Preventive physical exam	None
Office administered injectable drugs (except for sexual dysfunction)	$15 per visit
Office visits for consultation or care by a non-primary provider when referred by your primary care physician	$15 per visit
Allergy testing	$15 per visit
Eye and hearing examinations	$15 per visit
Family planning services.	$15 per visit

OUTPATIENT SERVICES	COST TO MEMBER
Outpatient surgery	$15 per visit
Outpatient Transgender surgery and related outpatient surgery services outpatient office visits, and related services, limited coverage**	$15 per visit
Laboratory, X-ray, electrocardiograms and all other tests.	None
Therapeutic injections, including allergy shots.	$5 per visit
All generally accepted cancer screening tests	None

HOSPITALIZATION SERVICES	COST TO MEMBER
Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:	$250 per admission
• 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	
• Inpatient Transgender surgery and services related to the surgery, limited coverage**	
• Rehabilitation services	
Professional inpatient services, including:.	None
• Physicians' services, including surgeons, anesthesiologists and consultants	
• Private-duty nurse when prescribed by a participating physician	

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URGENT AND EMERGENCY SERVICES	COST TO MEMBER
Outpatient care to treat an injury or the sudden onset of an acute illness within or outside the WHA Service Area:	
Physician's office	$15 per visit
Urgent care center	$15 per visit
Hospital emergency room (waived if admitted)	$50 per visit
Ambulance service as medically necessary or in a life-threatening emergency (including 911)	None

PRESCRIPTION COPAYMENTS FOR COVERED MEDICATIONS*	COST TO MEMBER
Walk-In Pharmacy (up to 30 day supply)	
• Tier 1 – Preferred generic medication	$5
• Tier 2 – Preferred brand name medication	$20
• Tier 3 – Non-Preferred medication	$35
Mail Order (up to 90 day supply)	
• Tier 1 – Preferred generic medication	$10
• Tier 2 – Preferred brand name medication	$40
• Tier 3 – Non-Preferred medication	$70
Retail — UC Medical Center Pharmacy (up to 90 day supply)	
• Tier 1 – Preferred generic medication	$10
• Tier 2 – Preferred brand name medication	$40
• Tier 3 – Non-Preferred medication	$70
Oral/self injectable medications for sexual dysfunction (8 doses per 30 day supply)	50% copay
Self-injectables (except for insulin and sexual dysfunction)	
• Tier 1 – Preferred generic medication	$5
• Tier 2 – Preferred brand name medication	$20
• Tier 3 – Non-Preferred medication	$35

DURABLE MEDICAL EQUIPMENT	COST TO MEMBER
Durable Medical Equipment (excluding orthotic and prosthetic devices) when determined by a participating physician to be medically necessary and when authorized in advance by WHA	None
Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA	None

BEHAVIORAL HEALTH SERVICES

Behavioral health services, including chemical dependency services, are not covered by WHA. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by your employer. You may reach UBH at (888) 440-8225.

HOME HEALTH SERVICES	COST TO MEMBER
Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year	None

OTHER HEALTH SERVICES	COST TO MEMBER
Skilled nursing facility, semi-private room and board, when medically necessary and arranged by a primary care physician, including drugs and prescribed ancillary services, up to 100 days per calendar year	None
Hearing Aids — one standard device per ear every 36 months ($2,000 benefit maximum)	50% copay
Outpatient rehabilitative services, including:	$15 per visit
• Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary	
• Short-term respiratory therapy, cardiac rehabilitation and pulmonary rehabilitation, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement	
Inpatient rehabilitation	$250 per admission
Infertility testing and treatment services, including drugs provided	50% 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.

** Transgender surgery and services related to the surgery require prior authorization by WHA and are subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each member, and applicable copayment, if any.