



## WESTERN HEALTH ADVANTAGE Winters Chamber of Commerce Plan Options

	<b>PREMIER 20 Rx E</b>	<b>ADVANTAGE 420 Rx E</b>	<b>HDH40W Rx W</b> Annual Deductible: \$1000 Individual \$2000 Family
<b>Outpatient Services</b>			
Physician Office Visits	\$20 per visit	\$20 per visit	\$40 per visit
Well Baby Care (0-2 yrs)	Covered in full	Covered in full	Covered in full
X-ray, lab & other tests	Covered in full	Covered in full	Covered in full
Allergy Testing/Shots	\$20 per visit/\$5 per visit	\$20 per visit/\$5 per visit	\$40 per visit/\$5 per visit
Periodic Physical Exams	\$20 per visit	\$20 per visit	\$40 per visit
Immunizations – Adult and Pediatric	Covered in full	Covered in full	Covered in full
Eye and Hearing Exams (all ages)	\$20 per visit	\$20 per visit	\$40 per visit
<b>Outpatient Surgery – Facility</b>	\$100 per visit	\$100 per visit	\$250 copay after Deductible
<b>Outpatient Surgery- Office</b>	\$20 per visit	\$20 per visit	\$40 per visit
<b>Inpatient Hospitalization</b>			
Hospital Inpatient Services and Supplies	Covered in full	\$500 per day, Days 1 to 5	\$500 per day after Deductible
<b>Skilled Nursing Care (up to 100 days per calendar year)</b>	Covered in full	\$500 per day, Days 1 to 5	\$500 per day after Deductible
<b>Mental Health/Chemical Dependency</b>			
Outpatient Combined Benefit Mental Health and Substance Abuse, up to 20 visits per calendar year	\$20 per visit	\$20 per visit	\$40 per visit
Inpatient Mental Health up to 20 days per calendar year	Covered in full	\$500 per day, Days 1 to 5	\$500 per day after Deductible
Inpatient Chemical Dependency; short-term detox only	Covered in full	\$500 per day, Days 1 to 5	\$500 per day after Deductible
<b>Severe Mental Illness</b>			
Outpatient visits	\$20 per visit	\$20 per visit	\$40 per visit
Inpatient Hospitalization	Covered in full	\$500 per day, Days 1 to 5	\$500 per day after Deductible
<b>Urgent/Emergency Care</b>			
Physician's Office	\$20 per visit	\$20 per visit	\$40 per visit
Emergency Room	\$100 per visit, waived if admitted	\$100 per visit, waived if admitted	\$100 per visit, after Deductible, waived if admitted
Urgent Care Facility	\$35 per visit	\$35 per visit	\$50 per visit
<b>Maximum Out of Pocket Per Calendar Year</b>	<b>\$1,500 per Individual \$2,500 per Family</b>	<b>\$2,500 per Individual \$4,500 per Family</b>	<b>\$4,000 per Individual \$8,000 per Family</b>
<b>Prescriptions **</b>			
	<b>RX E</b>	<b>RX E</b>	<b>Rx W</b>
Generic	\$10 copay	\$10 copay	\$10 copay
Brand Name	\$20 copay	\$20 copay	\$30 copay after \$150 Deductible
Non-Preferred Brand Name	\$30 copay	\$30 copay	\$50 copay after \$150 Deductible

\*\* Mail Order prescription services available

*Illustrative purposes only. Consult the Combined Evidence of Coverage and Disclosure for exact benefits, exclusions and limitations.*