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/DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

member responsibility	DEDUCTIBLE
	The medical and prescription deductibles are the amount of money a member or family must pay for certain covered services before WHA is responsible for those covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or the Family coverage amount, whichever is met first.
	MEDICAL
$1,000*	Self-only coverage
$1,000*	Individual with Family coverage
$2,000*	Family coverage
	PRESCRIPTION (Rx) — Tiers 2 – 4
$250*	Self-only coverage
$250*	Individual with Family coverage
$500*	Family coverage

ANNUAL OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. It includes the deductible and copayments. Once the deductible and copayment costs reach the annual out-of-pocket maximum, WHA will cover 100% of the covered services for the remainder of the calendar year. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

$6,750	Self-only coverage
$6,750	Individual with Family coverage
$13,500	Family coverage
none	Lifetime maximum

cost to member	Preventive Care Services
none	Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF • Annual physical examinations and well baby care • Immunizations, adult and pediatric • Women's preventive services • Routine prenatal care and lab tests, and first post-natal visit • Breast, cervical, prostate, colorectal and other generally accepted cancer screenings Note: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered "preventive," the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in this copayment summary.

Professional Services

$40 per visit	Office visits, primary care and other practitioners not listed below
$40 per visit	Office visits, specialist
none	Adult vision examination
none	Pediatric vision examination, up to age 19
none	Hearing examination
$40 per visit	Family planning services

cost to member	Outpatient Services
	Outpatient surgery
$40 per visit	• Performed in office setting
$500 per visit, after deductible	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests
none	X-ray and diagnostic imaging
$250 per visit	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots
	Hospitalization Services
$500 per day, days 1-5, after deductible	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, blood transfusion services, rehabilitative services, and nursery care for newborn babies
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:
$40 per visit	• Physician's office
$50 per visit	• Urgent care center
$275 per visit, after deductible	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Walk-in pharmacy (30-day supply)
$10	• Tier 1 - Preferred generic and certain preferred brand name medication
$50, after Rx deductible	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$75, after Rx deductible	• Tier 3 - Non-preferred medication[1]
20%, after Rx deductible*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the Rx deductible per 30-day supply (access to Tier 4 medications at walk-in pharmacies is subject to limitations)
	Mail order (up to 90-day supply)
$25	• Tier 1 - Preferred generic and certain preferred brand name medication
$125, after Rx deductible	• Tier 2 - Preferred brand name or non-preferred generic medication[1]
$187.50, after Rx deductible	• Tier 3 - Non-preferred medication[1]
20%, after Rx deductible*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $250 after the Rx deductible per 30-day supply, limited to a 30-day supply

Certain specialty drugs may be categorized outside Tier 4. To confirm the tier level for any drug, go online to mywha.org/pharmacy; refer to the Preferred Drug List (PDL).

Oral anti-cancer drugs will not exceed $200 after the Rx deductible for a 30-day supply.

The following prescription medications are covered at no cost to the member (generic required if available): aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication and women's contraceptives.

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

[1]Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment.**

cost to member	Durable Medical Equipment (DME)
20%*	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
$40	Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA

Behavioral Health Services

Mental Health Disorders and Substance Abuse

$40 per visit	• Office visit
none	• Outpatient services
$500 per day, days 1-5, after deductible	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
$125 per day, days 1-5, after deductible	• Inpatient hospital services — provided at a residential treatment center
none	• Inpatient professional services, including physician services

Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).

Other Health Services

none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
$500 per day, days 1-5, after deductible	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 benefit period
none	Hospice services
$40 per visit	Habilitation services
$40 per visit	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement
$500 per day, days 1-5, after deductible	Inpatient rehabilitation
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
$15 per visit	• Acupuncture
$15 per visit***	• Chiropractic care, up to 20 visits per year
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, including one of the following benefits: • One pair of glasses with standard lenses • One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, including the following benefits: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

* Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service.
** The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.
*** Copayments do not contribute to the medical out-of-pocket maximum.

MANAGING YOUR HIGH-DEDUCTIBLE PLAN

When you reach your annual out-of-pocket maximum described in this Copayment Summary, WHA will mail you a letter to inform you that you do not have to pay any more copayments or deductibles for covered services through the end of the calendar year. To review amounts applied to your annual deductible and out-of-pocket maximum, simply access your accumulator through mywha.org. 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.