

# GATEWAY 30 PLATINUM 90 HMO

**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**  
none Deductible amount

## ANNUAL OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. Once 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.

\$4,000 Self-only coverage  
\$4,000 Individual with Family coverage  
\$8,000 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. See additional benefit information at [mywha.org/preventive](http://mywha.org/preventive).

- 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: In order for a service to be considered "preventive," the service must be provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must be to obtain the preventive service. In the event you receive additional services that are not part of the preventive exam (for example, procedures or labs resulting from screenings or in response to your medical condition or symptoms), you will be responsible for the cost of those services as described in this copayment summary.

## Professional Services

\$30 per visit Office or virtual visits, primary care and other practitioners not listed below  
\$30 per visit Office or virtual visits, specialist  
none Adult vision examination  
none Pediatric vision examination, up to age 19  
none Hearing examination  
\$30 per visit Family planning services



**cost to member** **Outpatient Services**

- Outpatient surgery
  - Performed in office setting
- \$30 per visit
- \$100 per visit
  - Performed in facility — facility fees
  - Performed in facility — professional services
- none Dialysis, chemotherapy, infusion therapy and radiation therapy
- none Laboratory tests
- none X-ray and diagnostic imaging
- \$150 per visit Imaging (CT/PET scans and MRIs)
- \$5 per visit Therapeutic injections, including allergy shots

**Hospitalization Services**

- \$300 per day, days 1-3 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:

- \$30 per visit
  - Physician’s office or virtual visit
- \$35 per visit
  - Urgent care virtual visit
- \$50 per visit
  - Urgent care center
- \$150 per visit
  - Emergency room — facility fees (waived if admitted)
  - Emergency room — professional services
  - Ambulance service as medically necessary or in a life-threatening emergency (including 911)

**Prescription Coverage**

Walk-in pharmacy (30-day supply)

- \$5
  - Tier 1 - Preferred generic and certain preferred brand name medication
- \$30
  - Tier 2 - Preferred brand name and certain non-preferred generic medication<sup>1</sup>
- \$50
  - Tier 3 - Non-preferred (generic or brand) medication<sup>1</sup>
- 20%\*
  - Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of \$250 (access to Tier 4 medications at walk-in pharmacies is subject to limitations)

Mail order (up to 90-day supply)

- \$12.50
  - Tier 1 - Preferred generic and certain preferred brand name medication
- \$75
  - Tier 2 - Preferred brand name and certain non-preferred generic medication<sup>1</sup>
- \$125
  - Tier 3 - Non-preferred (generic or brand) medication<sup>1</sup>
- 20%\*
  - Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of \$250

Certain specialty drugs may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply. To confirm the tier level for any drug, go online to [mywha.org/Rx](http://mywha.org/Rx); refer to the Preferred Drug List (PDL).

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.

Members will pay the lesser of the applicable copayment, the actual cost, or the retail price of the prescription.

<sup>1</sup>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
- \$30 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 Use Disorders

- \$30 per visit • Office visit or virtual visit
- none • Outpatient other services
- \$300 per day, days 1-3 • Inpatient hospital services, including detoxification — provided at a participating acute care facility
- \$125 per day, days 1-3 • Inpatient hospital services — provided at a residential treatment center
- none • Inpatient professional services, including physician services

**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
- \$300 per day, days 1-3 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
- \$30 per visit Habilitation services
- \$30 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
- \$300 per day, days 1-3 Inpatient rehabilitation
- none Abortion and abortion-related service, including pre-abortion and follow-up services
- none Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at mywha.org.
- \$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, includes 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, includes the following benefits:
  - Diagnostic and preventive dental care at no cost
  - Basic dental care services
  - Major dental care services
  - Orthodontics when determined medically necessary

\* Percentage copayments are based on 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 out-of-pocket maximum.