WESTERN 1000/40/500 HMO PRIME

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 (including inpatient, outpatient surgery and emergency services)
$1,000*	Self-only coverage
$1,000*	Individual with Family coverage
$2,000*	Family coverage
	PRESCRIPTION (Rx) — for Tier 2 and Tier 3 medications
$150*	Self-only coverage or Individual with 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.
$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.
	• 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
$40 per visit	Office or virtual visit, primary care and other practitioners not listed below
$40 per visit	Office or virtual visit, specialist
$40 per visit**	Vision and hearing examinations
$40 per visit	Family planning services

Pending DMHC Approval

cost to member	Outpatient Services
	Outpatient surgery
$40 per visit	• Performed in office setting
$250 per visit after deductible*	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, chemotherapy, infusion therapy and radiation therapy
none	Laboratory tests, X-ray and diagnostic imaging
none	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots

	Hospitalization Services
$500 per day 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 or virtual visit
$45 per visit	• Urgent care virtual visit
$50 per visit	• Urgent care center
$100 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
	Outpatient prescription medications are covered under the prescription rider plan (see your Prescription Copayment Summary).

	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 or virtual visit
none	• Outpatient services
$500 per day after deductible*	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
$125 per day after deductible*	• Inpatient hospital services — provided at 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).

cost to member	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 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 calendar year
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 after deductible*	Inpatient rehabilitation
none	Abortion and abortion-related service, including pre-abortion and follow-up services
	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, up to 20 visits per year
$15 per visit**	• Chiropractic care, up to 20 visits per year

* Deductible or percentage copayments are based upon WHA's contracted rates with the provider of service.

** With the exception of pediatric vision exams, copayments for these specified services 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.