

WESTERN 1800/0/0 HDHP 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

- \$1,800* Self-only coverage
- \$3,000* Individual with Family coverage
- \$3,600* Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA is responsible for covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or Family coverage amount, whichever is met first. Once the deductible is met, the relevant copayment(s) will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services, as noted below. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

- \$3,600 Self-only coverage
- \$3,600 Individual with Family coverage
- \$7,200 Family coverage

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.

- none Lifetime maximum

cost to member SERVICES NOT SUBJECT TO DEDUCTIBLE

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.

- none Vision examination
- none Hearing examination

cost to member SERVICES SUBJECT TO DEDUCTIBLE

after deductible is met

Professional Services

- none Office or virtual visit, primary care and other practitioners not listed below
- none Office or virtual visit, specialist
- none Family planning services

cost to member **SERVICES SUBJECT TO DEDUCTIBLE**
after deductible is met

Outpatient Services

Outpatient surgery

- none • Performed in office setting
- none • 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)
- none Therapeutic injections, including allergy shots

Hospitalization Services

- none 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

- none • Physician's office or virtual visit
- none • Urgent care virtual visit
- none • Urgent care center
- none • Emergency room — facility fees
- 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)

- none • Tier 1 - Preferred generic and certain preferred brand name medication
- \$30 • Tier 2 - Preferred brand name and certain non-preferred generic medication¹
- \$50 • Tier 3 - Non-preferred (generic or brand) medication¹

Mail order (up to 90-day supply)

- none • Tier 1 - Preferred generic and certain preferred brand name medication
- \$75 • Tier 2 - Preferred brand name and certain non-preferred generic medication¹
- \$125 • Tier 3 - Non-preferred (generic or brand) medication¹

Other Prescription Coverage

- none Home self-injectable medication
- 50%* Erectile Dysfunction medication¹, up to \$250 maximum per 30-day supply
- none Aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication and women's contraceptives; generic required if available

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

Non-injectable specialty medication may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply.

¹Regardless 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 SERVICES SUBJECT TO DEDUCTIBLE
after deductible is met

Durable Medical Equipment (DME)

- none 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

Behavioral Health Services

Mental Health Disorders and Substance Abuse

- none • Office visit or virtual visit
- none • Outpatient services
- none • Inpatient hospital services, including detoxification — provided at a participating acute care facility
- none • 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).

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
- none 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
- none Habilitation services
- none 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
- none 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.
- none • Acupuncture, up to 20 visits per year
- none • Chiropractic care, up to 20 visits per year

* 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.

IMPORTANT: Health savings accounts (HSAs) are complex financial products. This plan is a high-deductible health care plan. While there is no obligation to have an HSA, WHA recommends that you consult your tax or financial advisor to discuss the benefits and determine whether this plan and HSAs are a good choice for you.

MANAGING YOUR HIGH-DEDUCTIBLE PLAN: The deductible and annual out-of-pocket maximum apply only to the covered services described in this Copayment Summary. Copayments and deductibles for any benefits purchased separately as a rider, including but not limited to infertility benefits, do not apply to this deductible or annual out-of-pocket maximum. 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.