westernhealth ADVANTAGE

GATEWAY 70 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.

ANNUAL DEDUCTIBLE

member responsibility	**Medical 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. 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.

member responsibility	**Out-of-Pocket Maximum**
$4,000	Self-only coverage
$4,000	Individual with Family coverage
$8,000	Family coverage
none	Lifetime maximum

COVERED WITHOUT COST-SHARING

Preventive care services and some prescription medications (generic required) are covered at no cost to the member, as outlined under EOC/DF section Preventive Services Covered without Cost-Sharing. 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
- Family planning, including FDA-approved contraception and sterilization procedures; counseling, education
- Aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication, contraceptives

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.

COVERED WITH COST-SHARING

cost to member	Percentage copayments are based on WHA's contracted rates with the provider of service

Professional Services

$20 per visit	Office or virtual visits, primary care and other practitioners not listed below
$20 per visit	Office or virtual visits, specialist
none	Vision and hearing examinations, including pediatric vision exam (up to age 19)

Outpatient Services

	Outpatient surgery
$20 per visit	• Performed in office setting (primary care/specialist copayment applies)
$150 per visit	• Performed in facility — facility fees
none	• 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

30%	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:
$20 per visit	• Physician's office or virtual visit (primary care/specialist copayment applies)
$25 per visit	• Urgent care virtual visit
$50 per visit	• Urgent care center
$150 per visit	• 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 Drug 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
$50	• Tier 3 - Non-preferred (generic or brand) medication
20% up to $250	• Tier 4 - Specialty medication when authorized in advance by WHA
	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
$125	• Tier 3 - Non-preferred (generic or brand) medication
20% up to $250	• Tier 4 - Specialty medication when authorized in advance by WHA

Members will pay the lesser of the applicable copayment, the actual cost, or the retail price of the prescription. Certain specialty drugs may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply; access to Tier 4 medications at walk-in pharmacies is subject to limitations. To confirm tier level for any drug, visit mywha.org/Rx; refer to the Preferred Drug List (PDL).

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. The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

COVERED WITH COST-SHARING

cost to member	Percentage copayments are based on WHA's contracted rates with the provider of service

Durable Medical Equipment (DME)

20%	Durable medical equipment when determined by a participating physician to be medically necessary and when authorized in advance by WHA
$20	Orthotic and prosthetic devices 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

$20 per visit	• Office or virtual visit
none	• Outpatient other services
30%	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
30%	• Inpatient hospital services — provided at 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
30%	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
$20 per visit	Habilitation services
$20 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
30%	Inpatient rehabilitation
none	Abortion and abortion-related services
$15 per visit	Acupuncture and chiropractic services are provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at mywha.org. • Acupuncture, up to 20 visits per year • Chiropractic care, up to 20 visits per year; copayments do not contribute to the medical out-of-pocket maximum
none	Pediatric eyewear is provided through EyeMed for members up to age 19. For complete benefit information, refer to your plan documents at mywha.org. Benefits include the following: • One pair of lenses or contact lenses (provider designated or 6-month supply) every 12 months • One pair of provider designated frames every 12 months
varies by service	Pediatric dental is provided through DeltaCare® USA for members up to age 19. For complete benefit information, refer to your plan documents at mywha.org. Benefits include the following: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary