



THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

| DEDUCTIBLE | COST TO MEMBER |
|---|-----------------------|
| Medical | None |
| In any calendar year we will not cover certain medications until the member meets the following deductible: | |
| Prescription (for Preferred brand name and Non-Preferred medications) | \$100 per member* |

| ANNUAL OUT-OF-POCKET MAXIMUM | COST TO MEMBER |
|---|-----------------------|
| The maximum out-of-pocket expense for a Member per calendar year is limited to either the Individual amount or Family amount, whichever is met first: | |
| Individual | \$2,500 |
| Family | \$5,000 |
| All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum. | |
| Lifetime maximum | None |

| PREVENTIVE CARE SERVICES | COST TO MEMBER |
|---|-----------------------|
| Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF. | None |
| Annual physical examinations and well baby care | None |
| Immunizations, adult and pediatric | None |
| Maternity care, after the initial diagnosis, pre and post-natal visits and laboratory tests | None |
| Breast, cervical, prostate and colorectal cancer screenings | None |
| Note: procedures resulting from screenings are not considered preventive care. | |

| PROFESSIONAL SERVICES | COST TO MEMBER |
|---|-----------------------|
| Office visits, primary care physician or specialist | \$25 per visit |
| Eye and hearing examinations | \$25 per visit |
| Family planning services. | \$25 per visit |

| OUTPATIENT SERVICES | COST TO MEMBER |
|--|-----------------------|
| Outpatient surgery (performed in office setting) | \$25 per visit |
| Outpatient surgery (facility) | \$300 per visit |
| Outpatient surgery (Ambulatory Surgical Center — ASC) | \$150 per visit |
| Laboratory, X-ray, electrocardiograms and all other tests. | \$25 per visit |
| MRI, CT and PET scans | None |
| Therapeutic injections, including allergy shots | \$5 per visit |
| Other generally accepted cancer screening tests | None |

| HOSPITALIZATION SERVICES | COST TO MEMBER |
|---|---------------------------------------|
| Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: | \$400 per day per admission, days 1-3 |
| <ul style="list-style-type: none"> • 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 | |
| Professional inpatient services, including: | None |
| <ul style="list-style-type: none"> • Physicians' services, including surgeons, anesthesiologists and consultants • Private-duty nurse when prescribed by a participating physician | |



| URGENT AND EMERGENCY SERVICES | COST TO MEMBER |
|---|--|
| Outpatient care to treat an injury or the sudden onset of an acute illness within or outside the WHA Service Area: | |
| Physician's office..... | \$25 per visit |
| Urgent care center..... | \$25 per visit |
| Hospital emergency room (waived if admitted)..... | \$150 per visit |
| Ambulance service as medically necessary or in a life-threatening emergency (including 911)..... | \$100 per trip |
| | |
| PRESCRIPTION COVERAGE | COST TO MEMBER |
| Walk-In Pharmacy (30 day supply) | |
| Preferred generic / Preferred brand name / Non-Preferred medication..... | \$15/\$30/\$50* |
| Mail Order (90 day supply) | |
| Preferred generic/ Preferred brand name/ Non-Preferred medication..... | \$37.50/\$75/\$125* |
| Infertility drugs (limited to a \$1,500 lifetime maximum)..... | 50% of allowed charges* |
| The following prescription medications are covered at no cost to the member (generic only): prenatal vitamins, folic acid, fluoride for preschool age children and tobacco cessation medication. | |
| | |
| DURABLE MEDICAL EQUIPMENT (DME) | COST TO MEMBER |
| 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% to annual maximum of \$2,500* |
| Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA..... | |
| | \$25 |
| | |
| BEHAVIORAL HEALTH SERVICES | COST TO MEMBER |
| Outpatient services for mental health disorders and substance abuse..... | |
| | \$25 per visit |
| Inpatient hospital services for the treatment of mental health disorders, provided at a: | |
| Participating acute care facility..... | \$400 per day per admission, days 1-3 |
| Residential treatment center or partial hospitalization..... | \$125 per day per admission, days 1-3 |
| Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED). | |
| Inpatient hospital services for substance abuse detoxification only, provided at a participating acute care facility..... | \$400 per day per admission, days 1-3 |
| Substance abuse rehabilitation is not covered on an outpatient or inpatient basis. | |
| | |
| OTHER HEALTH SERVICES | COST TO MEMBER |
| Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year..... | |
| | \$30 per visit |
| 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..... | |
| | \$400 per day per disability, days 1-3 |
| Outpatient rehabilitative services, including:..... | |
| | \$25 per visit |
| <ul style="list-style-type: none"> • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • Short-term respiratory therapy, cardiac rehabilitation and pulmonary rehabilitation, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement | |
| Inpatient rehabilitation..... | \$400 per day per admission, days 1-3 |
| Home self injectables, up to \$100 maximum copay per 30 day supply (self injectable specialty medications that cost over \$500 for a 30 day supply are limited to a 30 day supply; insulin is covered under the prescription benefit)..... | |
| | 20% copay* |
| Infertility evaluation and treatment (except in vitro fertilization)..... | 50% of allowed charges* |

* Copayments and the prescription deductible do not contribute to the out-of-pocket maximum (unless required for the management or treatment of diabetes or pediatric asthma supplies and equipment). Percentage copayment amounts are based on WHA's contracted rate.