

# CAPITAL 250 GOLD 80 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 DEDUCTIBLES

The **medical deductible** is 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. The **pharmacy deductible** amount is per member, even if enrolled as a family, and applies to covered medications. Once the deductible(s) are met, the relevant copayment(s) will apply. Amounts paid for non-covered services/medications do not count toward a member's deductibles.

|                       |                                                   |
|-----------------------|---------------------------------------------------|
| member responsibility | <b>Medical Deductible • AD = After Deductible</b> |
| \$250                 | Self-only coverage                                |
| \$250                 | Individual with Family coverage                   |
| \$500                 | Family coverage                                   |
| none                  | <b>Pharmacy Deductible</b>                        |

### ANNUAL OUT-OF-POCKET MAXIMUM

The **out-of-pocket maximum** is the most a member or family will pay in a calendar year for covered services/medications. Once the deductible and copayment costs reach the annual out-of-pocket maximum, WHA will cover 100% of the covered services/medications for the remainder of the calendar year. Amounts paid for non-covered services/medications do not count toward a member's out-of-pocket maximum.

|                       |                                 |
|-----------------------|---------------------------------|
| member responsibility | <b>Out-of-Pocket Maximum</b>    |
| \$7,800               | Self-only coverage              |
| \$7,800               | Individual with Family coverage |
| \$15,600              | Family coverage                 |
| none                  | Lifetime maximum                |

### COVERED WITHOUT COST-SHARING — NOT SUBJECT TO DEDUCTIBLE

**Preventive care services** and some Prescription medications 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](http://mywha.org/preventive).

- Annual physical examinations and well baby care
- Adult and pediatric immunizations, including those for flu and COVID-19
- 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
- Certain preventive medications and supplements, available as prescription and/or over-the-counter (OTC); see Prescription Drug Coverage section of this Copayment Summary for details

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 Deductible/percentage copayments are based on WHA's contracted rates with the provider of service

**Professional Services**

- \$35 per visit Office or virtual visits, primary care and other practitioners not listed below
- \$55 per visit Office or virtual visits, specialist

**Outpatient Services**

Outpatient surgery

- \$35/\$55 per visit • Performed in office setting (primary care/specialist copayment applies)
- \$300 per visit AD • Performed in facility — facility fees
- \$35 per visit • Performed in facility — professional services
- 20% Dialysis, chemotherapy, infusion therapy and radiation therapy
- \$35 per visit Laboratory tests
- \$55 per visit X-ray and diagnostic imaging
- \$250 per visit AD Imaging (CT/PET scans and MRIs)
- \$5 per visit Therapeutic injections, including allergy shots

**Hospitalization Services**

- \$600 per day, days 1-5 AD 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:

- \$35/\$55 per visit • Physician's office or virtual visit (primary care/specialist copayment applies)
- \$35 per visit • Urgent care virtual visit
- \$35 per visit • Urgent care center
- \$250 per visit AD • Emergency room — facility fees (waived if admitted)
- none • Emergency room — professional services
- \$250 per trip AD • Ambulance service as medically necessary or in a life-threatening emergency (including 911)

**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

- \$35 per visit • Office or virtual visit
- none • Outpatient other services
- \$600 per day, days 1-5 AD • Inpatient hospital services, including detoxification — provided at a participating acute care facility
- \$600 per day, days 1-5 AD • Inpatient hospital services — provided at residential treatment center
- none • Inpatient professional services, including physician services

**COVERED WITH COST-SHARING**

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

**Other Health Services**

- \$30 per visit 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 1-5 **AD** 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
- \$35 per visit Habilitation services
- \$35 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
- \$600 per day, days 1-5 **AD** Inpatient rehabilitation
- none Abortion and abortion-related services
- \$35 per visit Acupuncture, provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at [mywha.org](http://mywha.org).

**Pediatric Services**

Essential health benefits for members up to age 19. For complete benefit information, refer to your plan documents at [mywha.org](http://mywha.org).

- none Pediatric vision examination and eyewear, provided through Vision Service Plan (VSP). Benefits include:
- 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, provided through DeltaCare® USA. Benefits include:
- Diagnostic and preventive dental care at no cost
  - Basic dental care services
  - Major dental care services
  - Orthodontics when determined medically necessary

## **PRESCRIPTION DRUG COVERAGE**

Covered Prescription medications included in a member's Prescription drug plan are categorized as Tier 1, 2, 3 or 4 in WHA's Preferred Drug List (PDL). A member's PDL can be requested by calling WHA Member Services or viewed online at [mywha.org/Rx](http://mywha.org/Rx).

NOTE: All medications included in the PDL are evaluated regularly for their efficacy, quality, safety, similar alternatives, and cost to ensure rational, cost-effective use of pharmaceutical agents. A drug's presence on the PDL does not guarantee that the member's Participating Provider will prescribe the drug. There are a small number of drugs, regardless of tier, that may require prior authorization to ensure appropriate use based on criteria set by WHA.

**Preventive medications, supplements and vaccines:** Aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication, contraceptives, and preventive vaccines, including those for flu and COVID-19, are covered without member cost-sharing; see Appendix A in your EOC/DF for a complete list. Generic required if available.

## **COVERED WITH COST-SHARING**

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

### **Retail pharmacy (cost per 30-day supply)**

- \$15 • Tier 1: Preferred generic and certain preferred brand name medication
- \$40 • Tier 2: Preferred brand name and certain non-preferred generic medication
- \$70 • Tier 3: Non-preferred (generic or brand) medication

Participating Retail Pharmacies allow up to a 90-day supply on maintenance medication. The retail pharmacy copayment applies for each 30-day supply.

### **Home delivery pharmacy (cost per prescription, up to 100-day supply)**

- \$30 • Tier 1: Preferred generic and certain preferred brand name medication
- \$80 • Tier 2: Preferred brand name and certain non-preferred generic medication
- \$140 • Tier 3: Non-preferred (generic or brand) medication

### **Specialty pharmacy (cost per prescription, up to 30-day supply)**

- 20%, up to \$250 • Tier 4: Specialty and other higher-cost medication

Specialty medication must be ordered through Optum Specialty Pharmacy (delivered to home or medical office, depending on who administers the medication).

A member's copayment or cost share will not exceed the cost of the drug dispensed. If a Tier 1 medication is available and the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

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**MANAGING YOUR DEDUCTIBLE PLAN:** To review amounts applied to your annual deductible and out-of-pocket (OOP) maximum, simply access your accumulator at [mywha.org](http://mywha.org). If you have any questions about how much has been applied to your deductible or annual OOP maximum, or whether certain payments you have made apply to the OOP maximum, call WHA Member Services. Once you have satisfied your OOP maximum, you may request a written statement confirming that you do not have to pay any more copayment or deductible amounts for covered services through the end of the calendar year.