Western Health Advantage

WHA SILVER 87 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.

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
$800*	Self-only coverage
$800*	Individual with Family coverage
$1,600*	Family coverage
	PRESCRIPTION (Rx) – Tiers 1 – 4
$25*	Self-only coverage
$25*	Individual with Family coverage
$50*	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.
$3,000	Self-only coverage
$3,000	Individual with Family coverage
$6,000	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
$15 per visit	Office or virtual visits, primary care and other practitioners not listed below
$25 per visit	Office or virtual visits, specialist
none	Pediatric vision examination, up to age 19
$15/25 per visit+	Family planning services

COVERED CALIFORNIA™

cost to member	Outpatient Services
	Outpatient surgery
$15/25 per visit+	• Performed in office setting
15%*	• Performed in facility — facility fees
15%*	• Performed in facility — professional services
15%*	Dialysis, chemotherapy, infusion therapy and radiation therapy
$20 per visit	Laboratory tests
$40 per visit	X-ray and diagnostic imaging
$100 per visit	Imaging (CT/PET scans and MRIs)
none	Therapeutic injections, including allergy shots

	Hospitalization Services
25% 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
25%*	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:
$15/25 per visit+	• Physician's office or virtual visit
$15 per visit	• Urgent care virtual visit
$15 per visit	• Urgent care center
$150 per visit	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services (waived if admitted)
$75 per trip	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)

	Prescription Coverage
	Walk-in pharmacy (30-day supply)
$5 after Rx deductible	• Tier 1 - Preferred generic and certain preferred brand name medication
$25 after Rx deductible	• Tier 2 - Preferred brand name and certain non-preferred generic medication[1]
$45 after Rx deductible	• Tier 3 - Non-preferred (generic or brand) medication[1]
15% after Rx deductible*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $150 after Rx deductible (access to Tier 4 medications at walk-in pharmacies is subject to limitations)
	Mail order (up to 90-day supply)
$12.5 after Rx deductible	• Tier 1 - Preferred generic and certain preferred brand name medication
$62.5 after Rx deductible	• Tier 2 - Preferred brand name and certain non-preferred generic medication[1]
$112.5 after Rx deductible	• Tier 3 - Non-preferred (generic or brand) medication[1]
15% after Rx deductible*	• Tier 4 - Specialty medication when authorized in advance by WHA, up to a maximum of $150 after Rx deductible

Certain specialty drugs may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply. To confirm the tier level for any drug, go online to mywha.org/Rx; refer to the Preferred Drug List (PDL).

The following prescription medications are covered at no cost to the member (generic required if available): aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication and women's contraceptives.

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

[1]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.**

cost to member	
	Durable Medical Equipment (DME)
15%*	Durable medical equipment when determined by a participating physician to be medically necessary and when authorized in advance by WHA
15%*	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
$15 per visit	• Office or virtual visit
none	• Outpatient other services
25% after deductible*	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
25% after deductible*	• Inpatient hospital services — provided at residential treatment center
25%*	• Inpatient professional services, including physician services
	Other Health Services
$15 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
25% 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 benefit period
none	Hospice services
$15 per visit	Habilitation services
$15 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
25% after deductible*	Inpatient rehabilitation
none	Abortion and abortion-related service, including pre-abortion and follow-up services
$15 per visit	Acupuncture services, provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at mywha.org.
none	Pediatric eyewear per calendar year, provided through MES Vision, up to age 19, includes one of the following benefits: • One pair of glasses with standard lenses • One pair of standard hard or six pairs of standard soft contact lenses instead of glasses
See additional benefit information	Pediatric dental, provided through DeltaCare® USA, up to age 19, including the following benefits: • Diagnostic and preventive dental care at no cost • Basic dental care services • Major dental care services • Orthodontics when determined medically necessary

+ Primary Care Physician Copayment $15/Specialist Copayment $25

* Deductible or percentage copayments are based on 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.

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 at 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.