UC 106A

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.

cost to member	DEDUCTIBLE
none	Deductible amount

ANNUAL OUT-OF-POCKET MAXIMUM

The maximum out-of-pocket expense for a member per calendar year is limited to either the Self-only, Individual with Family or Family coverage amount, whichever is met first:

$1,000	Self-only coverage
$1,000	Individual with Family coverage
$3,000	Family coverage
none	Lifetime maximum

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 • 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: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered "preventive," the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in this copayment summary.

Professional Services

$20 per visit	Office visits, primary care physician (PCP)
$20 per visit	Office visits, specialist
none	Vision and hearing examinations
$20 per visit	Family planning services

Outpatient Services

	Outpatient surgery
$20 per visit	• Performed in office setting
$100 per visit	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests, X-ray and diagnostic imaging
none	Imaging (CT/PET scans and MRIs)
$20 per visit	Specialty drugs injected in office setting
$5 per visit	Therapeutic injections, including allergy shots

cost to member	Hospitalization Services
$250 per admission	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 • Inpatient transgender surgery and services related to the surgery***
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
$20 per visit	• Urgent care center
$75 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 Coverage
	Walk-in pharmacy (30-day supply)
$5	Tier 1 – Preferred generic medication
$25	Tier 2 – Preferred brand name medication[1]
$40	Tier 3 – Non-preferred medication[1]
	Mail order (up to 90-day supply)
$10	Tier 1 – Preferred generic medication
$50	Tier 2 – Preferred brand name medication[1]
$80	Tier 3 – Non-preferred medication[1]
	UC Medical Center Pharmacy/Retail Chain Pharmacies (90-day supply)
$10	Tier 1 – Preferred generic medication
$50	Tier 2 – Preferred brand name medication[1]
$80	Tier 3 – Non-preferred medication[1]
	Speciality Drugs
$40	Oral
$5/25/40	Self-Injectable
50%*	Sexual dysfunction (oral and injectable); 8 doses per 30-day supply
$25	Insulin (30-day supply)

Access to specialty medications at walk-in pharmacies is subject to limitations.

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

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the member will only be responsible for paying the actual cost of the medication.

[1]Members are required to pay the difference between a brand name and a generic drug plus the generic copay, when the generic is available. (Exceptions for medical necessity are available via prior authorization, if approved, the applicable brand copay applies.)

cost to member	
	Nicotine Replacement Therapy
none	Over-the-Counter (OTC) • Patch • Gum • Lozenge OTC products must be prescribed by a physican. Limitations: Standard treatment is 12 weeks.
none	Prescription • Nicotine inhaler • Nicotine spray • Bupropion (Generic)/Zyban (Brand) • Varenicline (Generic)/(Chantix (Brand)
	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
	Behavioral health services, including chemical dependency services, are not covered by WHA. They are covered through OPTUM Health, the supplemental coverage provided by your employer. You may reach OPTUM Health at 888.440.8225.
	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
50%*	Hearing Aids: includes one standard device per ear every 36 months ($2,000 benefit maximum)**
$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
$250 per admission	Inpatient rehabilitation
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
$20 per visit	• Acupuncture
$20 per visit**	• Chiropractic care
	NOTE: 24 visits per year maximum (chiropractic and acupunture combined)
50%*	Infertility testing and treatment services, including drugs provided**
none	Diabetic supplies

* Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
** Copayments do not contribute to the out-of-pocket maximum.
*** Transgender surgery and services related to the surgery require prior authorization by WHA.

Western Health Advantage

HEARING AID BENEFIT

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cost to member

50%*

HEARING AID INSTRUMENT AND ANCILLARY EQUIPMENT

Includes a standard device for both ears every 36 months ($2,000 benefit maximum)

Benefit includes:

- Monaural or binaural including ear mold(s);
- Initial battery, cords and other ancillary equipment;
- Visits for fitting, counseling, adjustments, repairs at no charge for a one-year period following the provision of a covered hearing aid (after the one-year period expires, the member is responsible for all charges).

EXCLUSIONS

The purchases of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss; replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of hearing aid more than once in any period of 36 months.

HOW TO OBTAIN A HEARING AID

1. Talk to your doctor about your hearing difficulty.
2. Your primary care physician will coordinate a referral to an audiologist and obtain any necessary prior authorization.
3. You will then be contacted and advised how to schedule an exam with an audiologist.
4. If deemed necessary after that exam, hearing aid instruments and ancillary equipment will be coordinated for you by your doctor and/or the audiologist.

* Member's share of cost for covered hearing aid devices does not contribute to the annual out-of-pocket maximum of your medical plan with Western Health Advantage.

Percentage copayment amounts are based on WHA's contracted rate.

Western Health Advantage

INFERTILITY BENEFIT

COPAYMENT SUMMARY

INFERTILITY SERVICES

Covered Infertility services generally include consultations, examinations, diagnostic services whether performed in a physician's office or in a hospital or other facility, and medications. All covered Infertility services, including the diagnostic work-up and testing to establish a cause of "Infertility", require a 50% copayment, which is based on WHA's contracted charges. All covered Infertility services must receive prior authorization and are subject to the exclusions and limitations set forth in this Copayment Summary.

"Infertility" is defined as a condition of being infertile. A member is considered infertile if there is the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility or she or he is unable to conceive a pregnancy or to carry a pregnancy to a live birth or produce conception after one (1) year of regular, unprotected heterosexual intercourse, or if the female partner is over age 35 years, after 6 months of regular, unprotected heterosexual intercourse. A woman without a male partner may be considered infertile if she is unable to conceive after at least 12 cycles of supervised artificial/donor insemination (6 cycles for women 35 years or older).

COVERED SERVICES — 50% COPAYMENT*

- Services and supplies for diagnosis and treatment of involuntary infertility
- Artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime+
- Medications for the treatment of Infertility.

Genetic testing and counseling are covered benefits when medically indicated and are not subject to the Infertility Benefit copayments.

EXCLUSIONS AND LIMITATIONS

In addition to exclusions and limitations described under Covered Services, the following apply:

- The member must be diagnosed with "Infertility" as defined in this Copayment Summary.
- All covered Infertility services must be prior authorized by WHA.
- Services and supplies to reverse voluntary, surgically induced infertility are excluded.
- All services involved in surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded.
- In Vitro Fertilization (IVF)
- Gamete Intra-Fallopian Transfer (GIFT)
- Frozen embryo transfers and Zygote Intra-Fallopian Transfer (ZIFT) are excluded.
- Intracytoplasmic Sperm Injection (ICSI) is excluded.
- Ova sticks (a self-test for infertility) are excluded.
- Ovum transfer/transplants or uterine lavage as part of infertility diagnosis or treatment is excluded.
- All services related to the sperm donor, including the collection of the sperm, are excluded.
- Sperm storage is excluded.
- Treatment of infertility as a result of previous/prevailing elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts, is excluded.
- Artificial insemination in the absence of a diagnosis of Infertility is excluded.
- Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome) is excluded.
- Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of infertility are excluded.
- Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos are excluded.
- Inoculation of a woman with partner's white cells is excluded (considered experimental).

* Copayments for covered Infertility services do not contribute to the annual out-of-pocket maximum of your medical plan with Western Health Advantage.

+"Lifetime" refers to services obtained during the member's life, including services provided under any other health insurance or HMO.