WESTERN 1000/20/20% HMO PRIME with Rx Plus

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	**Medical Deductible** • AD = After Deductible
$1,000	Self-only coverage
$1,000	Individual with Family coverage
$2,000	Family coverage
$250	**Pharmacy Deductible**

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	**Out-of-Pocket Maximum**
$5,000	Self-only coverage
$5,000	Individual with Family coverage
$10,000	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.

- 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

$20 per visit	Office or virtual visits, primary care and other practitioners not listed below
$20 per visit	Office or virtual visits, specialist
none	Annual vision examination, when provided through Vision Service Plan (VSP)
$20 per visit	Annual hearing examination; copayments do not contribute to the medical out-of-pocket maximum

Outpatient Services

	Outpatient surgery
$20 per visit	• Performed in office setting
$250 per visit **AD**	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, chemotherapy, infusion therapy and radiation therapy
none	Laboratory tests, X-ray and diagnostic imaging
none	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots

Hospitalization Services

20% **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
20% **AD**	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
$25 per visit	• Urgent care virtual visit
$50 per visit	• Urgent care center
20% **AD**	• Emergency room — facility fees (waived if admitted)
20% **AD**	• Emergency room — professional services (waived if admitted)
none	• 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
$20 per visit	• Office or virtual visit
none	• Outpatient other services
20% **AD**	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
20% **AD**	• Inpatient hospital services — provided at residential treatment center
20% **AD**	• 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

none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
20% **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 calendar year
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
20% **AD**	Inpatient rehabilitation
none	Abortion and abortion-related services
$15 per visit	Acupuncture and chiropractic services, 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

PRESCRIPTION DRUG COVERAGE

Covered 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.

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.

PRESCRIPTION DEDUCTIBLE (TIERS 2 – 4) • AD Rx = After Prescription Deductible

$250 per member per calendar year — The **pharmacy deductible** amount is per member, even if enrolled as a family, and applies to covered medications. Once the deductible is met, the relevant copayment(s) will apply. Amounts paid for non-covered medications do not count toward a member's deductibles.

COVERED WITH COST-SHARING

Retail pharmacy (cost per 30-day supply)

- $15 • Tier 1: Preferred generic and certain preferred brand name medication
- $30 **AD Rx** • Tier 2: Preferred brand name and certain non-preferred generic medication
- $50 **AD Rx** • 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
- $60 **AD Rx** • Tier 2: Preferred brand name and certain non-preferred generic medication
- $100 **AD Rx** • Tier 3: Non-preferred (generic or brand) medication

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

- $100 **AD Rx** • 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.

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. 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.

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INFERTILITY A BENEFIT

COPAYMENT SUMMARY

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 a presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or the member is unable to conceive a pregnancy or to carry a pregnancy to a live birth after one (1) year of regular unprotected intercourse, or if the member is over age 35 years, after 6 months of regular unprotected intercourse. A member not having regular unprotected intercourse may be considered infertile if conception does not occur after at least 12 cycles of supervised artificial/donor insemination (6 cycles for members 35 years or older).

Covered Services
50% Copayment*

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

- 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+
- One Gamete Intra-Fallopian Transfer (GIFT) or In Vitro Fertilization (IVF) per Lifetime+
- Medications for the treatment of Infertility

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.
- 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.

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FAMILY & DIVERSITY SUPPORT BENEFIT

COPAYMENT SUMMARY

Planning for a routine pregnancy may require support services. Western Health Advantage's Family and Diversity Support Benefit provides assistance for members seeking pregnancy or for members with a known rare and severe genetic trait who may need support to conceive.

	Pregnancy Support	Pre-Implantation Genetic Testing
Covered Services	Up to three (3) cycles of artificial insemination or sperm collection per lifetime[1] and medications for ovarian stimulation, including basic laboratory and imaging tests related to fertility workup	Pre-implantation genetic testing
When the member is eligible for the covered services	Any member, with referral from provider.	A member has a personal or first degree relative with a WHA-listed genetic condition[2], OR A fetus from a member's prior pregnancy was determined to have one of the WHA-listed genetic condition[2], OR Both partners are carriers of a WHA-listed genetic condition[2], OR One partner is a carrier of a WHA-listed genetic condition[2] that is a dominant trait condition. If a member is found to be a carrier through pre-conception screening and the partner is a WHA member, the partner may be covered for carrier testing.
Prior Authorization	Required	Required
Copayment	50%[3]	50%[3]
Exclusions & Limitations	• Not for treatment of infertility. • Not covered after sterilization or sterilization reversal procedures. • Benefit ends when a viable pregnancy is achieved or three (3) cycles per lifetime[1] have occurred. • If a pregnancy ends in miscarriage, additional cycles up to the total of three (3) can be covered. • Donor semen or eggs including services and supplies to their procurement and storage are not covered. • Excludes genetic testing and advanced imaging • All surrogacy services are not covered.	• May be covered in conjunction with infertility benefit when the member's employer offers infertility benefits. Donor semen or eggs including services and supplies to their procurement and storage are not covered.

[1] "Lifetime" refers to any attempts, treatments or services rendered during the member's coverage under a Western Health Advantage plan at any time during the member's lifetime.

[2] Western Health Advantage maintains a list of rare and severe genetic conditions, which may be updated with new conditions over time.

[3] Copayments for covered Family and Diversity Support services do not contribute to the annual out-of-pocket maximum of your medical plan with Western Health Advantage. Percentage copayments are based upon WHA's contracted rates with the provider of the service.

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 711 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 711.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 711 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於 Western Health Advantage**方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話**888.563.2250**或聽障人士專線**(TTY) 711**。**

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 711.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 711.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 711로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 711՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث اَدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره711 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 711.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、711までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 711.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 711 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ,
អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន
នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់
អ្នកត្រចៀកថ្លង់ តាមលេខ 711។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 711.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 711 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY
สำหรับคนหูหนวกโดยโทร 711