

PREMIER 0/20/0 HMO PRIME

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	none Deductible amount
ANNUAL OUT-OF-POCKET MAXIMUM	The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. Once 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.
\$1,500	Self-only coverage
\$1,500	Individual with Family coverage
\$2,500	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 .
	<ul style="list-style-type: none"> • 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. See additional benefit information at mywha.org/preventive .
Professional Services	
\$20 per visit	Office or virtual visits, primary care physician (PCP)
\$20 per visit	Office or virtual visits, specialist
\$20 per visit**	Vision and hearing examinations
\$20 per visit	Family planning services
Outpatient Services	
	Outpatient surgery
\$20 per visit	<ul style="list-style-type: none"> • Performed in office setting
\$100 per visit	<ul style="list-style-type: none"> • Performed in facility — facility fees
none	<ul style="list-style-type: 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	
none	Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: <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
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services

cost to member Urgent and Emergency Services

Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area:

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|-----------------|---|
| \$20 per visit | • Physician's office or virtual visit |
| \$25 per visit | • Urgent care virtual visit |
| \$35 per visit | • Urgent care center |
| \$100 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

Outpatient prescription medications are covered under the prescription rider plan (see your Prescription Copayment Summary).

Durable Medical Equipment (DME)

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| 20%* | 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 |
| \$20 | Orthotics and prosthetics 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 Abuse

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| \$20 per visit | • Office or virtual visits |
| none | • Outpatient services |
| none | • Inpatient hospital services, including detoxification — provided at a participating acute care facility |
| none | • Inpatient hospital services — provided at residential treatment center |
| none | • Inpatient professional services, including physician services |
- Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).

Other Health Services

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| 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 |
| none | Hospice services |
| \$20 per visit | Habilitation services |
| \$20 per visit | Outpatient rehabilitative services, including: <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 • 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 |
| none | Inpatient rehabilitation |
| | Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at mywha.org . |
| \$15 per visit | • Acupuncture, up to 20 visits per year |
| \$15 per visit** | • Chiropractic care, up to 20 visits per year |

* Percentage copayments are based upon WHA's contracted rates with the provider of service.

** With the exception of pediatric vision exams, copayments for these specified services do not contribute to the medical out-of-pocket maximum.