CAPITAL 20 PLATINUM 90 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 DEDUCTIBLE

member responsibility	**Medical Deductible**
none	Deductible amount

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 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**
$4,500	Self-only coverage
$4,500	Individual with Family coverage
$9,000	Family coverage
none	Lifetime maximum

COVERED WITHOUT COST-SHARING

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	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
$30 per visit	Office or virtual visits, specialist

Outpatient Services

Outpatient surgery

$20/$30 per visit	• Performed in office setting (primary care/specialist copayment applies)
$100 per visit	• Performed in facility — facility fees
$25 per visit	• Performed in facility — professional services
10%	Dialysis, chemotherapy, infusion therapy and radiation therapy
$20 per visit	Laboratory tests
$30 per visit	X-ray and diagnostic imaging
$100 per visit	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots

Hospitalization Services

$250 per day, days 1-5	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:

$20/$30 per visit	• Physician's office or virtual visit (primary care/specialist copayment applies)
$20 per visit	• Urgent care virtual visit
$20 per visit	• Urgent care center
$150 per visit	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
$150 per trip	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)

Durable Medical Equipment (DME)

10%	Durable medical equipment when determined by a participating physician to be medically necessary and when authorized in advance by WHA
10%	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
$250 per day, days 1-5	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
$250 per day, days 1-5	• Inpatient hospital services — provided at residential treatment center
none	• Inpatient professional services, including physician services

COVERED WITH COST-SHARING

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

Other Health Services

$20 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
$150 per day, days 1-5	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
$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 day, days 1-5	Inpatient rehabilitation
none	Abortion and abortion-related services
$20 per visit	Acupuncture, provided through Landmark Healthplan of California, Inc., no PCP referral required. See additional benefit information at 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.

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.

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)
$5	• Tier 1: Preferred generic and certain preferred brand name medication
$20	• Tier 2: Preferred brand name and certain non-preferred generic medication
$30	• 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)
$10	• Tier 1: Preferred generic and certain preferred brand name medication
$40	• Tier 2: Preferred brand name and certain non-preferred generic medication
$60	• Tier 3: Non-preferred (generic or brand) medication
	Specialty pharmacy (cost per prescription, up to 30-day supply)
10%, 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 contribute to the out-of-pocket maximum.

MANAGING YOUR TRADITIONAL PLAN: To review amounts applied to your 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 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 amounts for covered services through the end of the calendar year.