

PREMIER 20

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:

\$1,500 Self-only coverage
 \$1,500 Individual with Family coverage
 \$2,500 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
 \$20 per visit** 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)
 \$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:
 • 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:

- \$20 per visit • Physician's office
- \$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 excluded, unless the Employer has selected an optional prescription rider plan (see your Prescription Copayment Summary, if applicable).

Durable Medical Equipment (DME)

- 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

- \$20 per visit • Office visit
- 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

- 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:
 - 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
- 20%* Home self-injectable medication, up to \$100 maximum copay per 30-day supply, limited to a 30-day supply; insulin is covered under the prescription benefit
- Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
- \$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.

** Copayments do not contribute to the medical out-of-pocket maximum.