WESTERN 2800B HSA

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
$2,800*	Self-only coverage
$2,800*	Individual with Family coverage
$5,600*	Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA will cover those services. After the deductible is met the applicable copayments will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services as noted below. The deductible is applied each calendar year. Each Individual with Family coverage must meet the Individual amount before WHA becomes responsible for providing covered services for that individual in the family, unless the family meets the Family amount first. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

$4,000	Self-only coverage
$4,000	Individual with Family coverage
$8,000	Family coverage

The out-of-pocket maximum is the maximum total amount of copayments and deductibles that a member or the family must pay for covered services during any calendar year. Each Individual with Family coverage must meet the Individual amount before you do not have to pay any more copayments or deductibles for that calendar year, unless the family meets the Family amount first. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

none	Lifetime maximum

cost to member	SERVICES NOT SUBJECT TO DEDUCTIBLE
	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.

none	Vision examination
none	Hearing examination

IMPORTANT: Health savings accounts (HSAs) are complex financial products. This plan is a high-deductible health care plan. While there is no obligation to have an HSA, WHA recommends that you consult your tax or financial advisor to discuss the benefits and determine whether this plan and HSAs are a good choice for you.

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE
	Professional Services
$40 per visit	Office visits, primary care physician (PCP)
$40 per visit	Office visits, specialist
$40 per visit	Family planning services
	Outpatient Services
	Outpatient surgery
$40 per visit	• Performed in office setting
$250 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
$500 per day	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
$40 per visit	• Physician's office
$50 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
	Walk-in pharmacy (30-day supply)
$10	• Tier 1 - Preferred generic medication
$30	• Tier 2 - Preferred brand name medication[1]
$50	• Tier 3 - Non-preferred medication[1]
	Mail order (up to 90-day supply)
$25	• Tier 1 - Preferred generic medication
$75	• Tier 2 - Preferred brand name medication[1]
$125	• Tier 3 - Non-preferred medication[1]

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, tobacco cessation medication 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]Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment.

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE

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
$40	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

$40 per visit	• Office visit
none	• Outpatient services
$500 per day	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
$125 per day	• 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
$500 per day	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
$40 per visit	Habilitation services
$40 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
$500 per day	Inpatient rehabilitation
20%*	Home self-injectable medication, up to $100 maximum copay for a 30-day supply, limited to a 30-day supply; insulin is covered under the prescription benefit

cost to member	SERVICES NOT SUBJECT TO DEDUCTIBLE

Additional Health Services

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

* Deductibles or 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.

MANAGING YOUR HIGH-DEDUCTIBLE PLAN

The deductible and annual out-of-pocket maximum apply only to the covered services described in this Copayment Summary. Copayments and deductibles for any benefits purchased separately as a rider, including but not limited to infertility benefits, do not apply to this deductible or annual out-of-pocket maximum.

When your copayments and deductible payments for the services described in this Copayment Summary have reached the annual out-of-pocket maximum, WHA will automatically provide you a document to show that you do not have to pay any more copayments or deductibles for covered services through the end of the calendar year.

To review amounts applied to your annual deductible and out-of-pocket maximum, simply access your accumulator through MyWHA at westernhealth.com.

If you have any questions about how much has been applied to your deductible or annual out-of-pocket maximum, or whether certain payments you have made apply to the annual out-of-pocket maximum, please call WHA Member Services.