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.

<table>
<thead>
<tr>
<th>Member Responsibility</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,800* Self-only coverage</td>
</tr>
<tr>
<td></td>
<td>$2,800* Individual with Family coverage</td>
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<tr>
<td></td>
<td>$3,600* Family coverage</td>
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</tbody>
</table>

The annual deductible is the amount of money a member or family must pay for covered services before WHA is responsible for covered services. Each member enrolled as a family must meet the Individual with Family coverage amount or Family coverage amount, whichever is met first. Once the deductible is met, the relevant copayment(s) will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services, as noted below. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

<table>
<thead>
<tr>
<th></th>
<th>Self-only coverage</th>
<th>Individual with Family coverage</th>
<th>Family coverage</th>
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<tbody>
<tr>
<td>$3,600</td>
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<td>$7,200</td>
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The out-of-pocket maximum is the most a member will pay in a calendar year for covered services. It includes the deductible and copayment costs. Once the deductible and 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.

SERVICES NOT SUBJECT TO DEDUCTIBLE

- 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.
  - 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.

<table>
<thead>
<tr>
<th></th>
<th>Vision examination</th>
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<tr>
<td></td>
<td>Hearing examination</td>
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SERVICES SUBJECT TO DEDUCTIBLE

<table>
<thead>
<tr>
<th>Professional Services</th>
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</thead>
<tbody>
<tr>
<td>Office or virtual visits, primary care physician (PCP)</td>
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<tr>
<td>Office or virtual visits, specialist</td>
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<tr>
<td>Family planning services</td>
</tr>
</tbody>
</table>
SERVICES SUBJECT TO DEDUCTIBLE

Outpatient Services
Outpatient surgery
none
• Performed in office setting
none
• 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)
none
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

Urgent and Emergency Services
Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area
none
• Physician's office or virtual visit
none
• Urgent care virtual visit
none
• Urgent care center
none
• Emergency room — facility fees
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)
none
• Tier 1 - Preferred generic and certain preferred brand name medication
$30
• Tier 2 - Preferred brand name and certain non-preferred generic medication
$50
• Tier 3 - Non-preferred (generic or brand) medication
Mail order (up to 90-day supply)
none
• Tier 1 - Preferred generic and certain preferred brand name medication
$75
• Tier 2 - Preferred brand name and certain non-preferred generic medication
$125
• Tier 3 - Non-preferred (generic or brand) medication
Other Prescription Coverage
none
Home self-injectable medication
50%*
Erectile Dysfunction medication, up to $250 maximum per 30-day supply
none
Aspirin, folic acid (including in prenatal vitamins), fluoride for preschool age children, tobacco cessation medication and women's contraceptives; generic required if available

Members will pay the lesser of the applicable copayment, the actual cost, or the retail price of the prescription. Non-injectable specialty medication may be classified on Tiers 1-3. Regardless of tier, all specialty medications are limited to a 30-day supply.

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.
Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service. The amount paid for the difference in cost does not apply to the deductible or contribute to the out-of-pocket maximum.

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.

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 you reach your annual out-of-pocket maximum described in this Copayment Summary, WHA will mail you a letter to inform you 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.org. 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.
INFERTILITY BENEFIT

COPAYMENT SUMMARY

INFERTILITY SERVICES
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 the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility or she or he is unable to conceive a pregnancy or to carry a pregnancy to a live birth or produce conception after one (1) year of regular, unprotected heterosexual intercourse, or if the female partner is over age 35 years, after 6 months of regular, unprotected heterosexual intercourse. A woman without a male partner may be considered infertile if she is unable to conceive after at least 12 cycles of supervised artificial/donor insemination (6 cycles for women 35 years or older).

COVERED SERVICES — 50% COPAYMENT*

- 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 per Lifetime+
- Medications for the treatment of Infertility

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

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.