University of California 106A

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 AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLE	**YOU PAY**
Deductible amount	None

ANNUAL OUT-OF-POCKET MAXIMUM	**YOU PAY**

All copayments listed on this Copayment Summary not marked with a * apply to the out-of-pocket maximum.
The maximum out-of-pocket expense for Members per calendar year is limited to:

Individual	$1,000
Family	$3,000
Lifetime maximum	None

PROFESSIONAL SERVICES YOU PAY	
Office visits for adult and pediatric care	$15 per visit
Well-baby care, birth up to two years	Covered in full
Maternity care, after the initial diagnosis, pre and post-natal visits	Covered in full
Office administered preventive immunizations	Covered in full
Physical exams	Covered in full
Office administered injectable drugs (except for sexual dysfunction)	$15 per visit
Office visits for consultation or care by a non-primary provider when referred by your primary care physician	$15 per visit
Allergy testing	$15 per visit
Eye and hearing examinations	$15 per visit
Family planning services	$15 per visit

OUTPATIENT SERVICES YOU PAY	
Outpatient surgery	$15 per visit
Outpatient transgender surgery and related outpatient surgery services, outpatient office visits, and related services, limited coverage**	$15 per visit
Laboratory, X-ray, electrocardiograms and all other tests	Covered in full
Therapeutic injections, including allergy shots	$5 per visit
Infertility testing and treatment services, including drugs provided	50% copay
All generally accepted cancer screening tests	Covered in full

HOSPITALIZATION SERVICES YOU PAY

Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: $250 per admission

- 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 and nursery care for newborn babies
- Blood transfusion services
- Inpatient transgender surgery and services related to the surgery, limited coverage**

Professional inpatient services, including: $250 per admission

- Physicians' services, including surgeons, anesthesiologists and consultants
- Private-duty nurse when prescribed by a participating physician

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URGENT AND EMERGENCY SERVICES	**YOU PAY**
Outpatient care to treat an injury or the sudden onset of an acute illness within or out of the WHA Service Area:	
Physician's office	$15 per visit
Urgent care center	$15 per visit
Hospital emergency room (waived if admitted)	$50 per visit
Ambulance service as medically necessary or in a life-threatening emergency (including 911)	Covered in full

PRESCRIPTION COPAYMENTS FOR COVERED MEDICATIONS*	**YOU PAY**
Walk-In Pharmacy (up to 30-day supply)	
Preferred generic medications	$10
Preferred brand name medications	$20
Non-Preferred medications	$35
Mail Order (up to 90-day supply)	
Preferred generic medications	$20
Preferred brand name medications	$40
Non-Preferred medications	$70
Retail — UC Medical Center Pharmacy (up to 90-day supply)	
Preferred generic medications	$20
Preferred brand name medications	$40
Non-Preferred medications	$70
Oral/self-injectables — sexual dysfunction (8 doses per 30-day supply)	50% of charges
Self-injectables (except for insulin and sexual dysfunction)	
Preferred generic medications	$10
Preferred brand name medications	$20
Non-Preferred medications	$35

DURABLE MEDICAL EQUIPMENT	**YOU PAY**
Durable Medical Equipment (DME) and prosthetic/orthotic devices when determined by a participating physician to be medically necessary and when authorized in advance by WHA	Covered in full

HOME HEALTH SERVICES	**YOU PAY**
Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year	Covered in full

OTHER HEALTH SERVICES YOU PAY	
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	Covered in full
Hearing Aids — one standard device per ear every 36 months ($2,000 benefit maximum)	50% copay
Short-term rehabilitative services including physical therapy, speech therapy, respiratory therapy or an organized program of such services:	
Outpatient rehabilitation	$15 per visit
Inpatient rehabilitation	$250 per admission

*Copayments do not contribute to the out-of-pocket maximum (unless required for the management or treatment of diabetes or pediatric asthma supplies and equipment). Percentage copayment amounts are based on WHA's contracted rate.

**Transgender surgery and services related to the surgery require prior authorization by WHA and is subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each member, and applicable copayment, if any.