westernhealth ADVANTAGE

WHA Certification Training

Understand the basics of Medicare Advantage Prescription Drug (MAPD) plans offered by Western Health Advantage

WHAT WE WILL COVER TODAY

- Training Disclosure
- All About WHA
- Selling for WHA
- Sales & Marketing Standards
- Sales & Education Events
- Contacts & Appointments
- Plan Rules
- Understanding an HMO
- Prescription Plan
- Appeals & Grievances
- Medicare Enrollment
- 2024 Plan Offering

Certification Training Disclosure

This training presentation is intended for use by licensed agents to understand the basics of Medicare Advantage Prescription Drug (MAPD) plans offered by Western Health Advantage.

Information contained in this document regarding 2024 plan service areas, benefits, costs, etc. is **confidential until general release to the public on October 1, 2023**.

Distribution to consumers, other insurers, or any other person or company is strictly prohibited. Failure to comply with this requirement will result in the loss of appointment with Western Health Advantage and may result in a civil monetary judgment.

Mission

We expand access to health care and respond to the changing needs of our members, providers and community to improve the health and well-being of all.

Who We Are

- Designed to offer greater access to medical care — not your typical HMO
- Founded by Dignity Health (Sacramento) and NorthBay Health (Solano); supported by a coalition of exceptional doctors and hospital systems across Northern California
- 501(c)(4) tax-exempt nonprofit public benefit corporation
- Nearly 260 Northern CA-based WHA employees providing dedicated service to more than 105k group and individual members
- Serving our communities across Northern California for nearly 25 years

Community Focused

We support the communities where we live and work. As a regional company, most of our economic impact is felt right here, from employing local people and supporting local businesses to charitable giving and volunteerism.

Recognized Health Partner

- “Commendable” accreditation given by the National Committee for Quality Assurance
- Longstanding partner to employer groups — large and small — including CalPERS
- Individual offering — direct and through the state marketplace

Why WHA Medicare

- WHA offers highly competitive, robust Medicare Advantage plans
- WHA's strong relationships with providers and hospitals, coupled with our commitment to customer service, is a welcomed option for our Medicare-eligible neighbors and your clients
- Allows existing WHA members aging into Medicare an easy transition, maintaining continuity of care and the ability to keep their same doctors

WHA's Service Area: 7 Counties

WHA offers Medicare Advantage plans* in these Northern California counties:

- Humboldt
- Marin
- Napa
- Sacramento
- Solano
- Sonoma
- Yolo

*plan availability varies by county

WHA's Network: 6 Medical Groups

WHA's Medicare Advantage plans offer access to clinical providers and facilities from these medical groups:

- Hill Physicians
- Mercy Medical Group
- Meritage Medical Network
- NorthBay Health
- Providence
- Woodland Clinic

Specialty Care Options: Advantage Referral

Members have choices for specialist referrals beyond their PCP's medical group. WHA's Advantage Referral program provides access to specialists from our six medical groups, expanding access to specialty care outside of their PCP's medical group (some limitations apply).

Selling for Western Health Advantage

- Brokers/agents are required to participate in annual training and testing on Medicare rules, regulations, and on details specific to the plan products they sell
- Passing product certification and the American Health Insurance Plan (AHIP) certification are annual requirements
- You must be currently appointed with Western Health Advantage or endorsed by an agency that is appointed to Western Health Advantage
- WHA will terminate its relationship with any agent/broker for contract violations or fraud

Selling for Western Health Advantage

- Brokers/agents must be compliant
- Adherence to all CMS rules on marketing and sales is a must — you may be “secret shopped” by WHA to ensure compliance
- Brokers/agents must maintain current state licensure
- You must be prepared to show a copy of your license if asked by a beneficiary
- Brokers/agents must remain free and clear from any sanctions which would prevent them from participating in a federal program

CMS Marketing Material Highlights

Materials

Brokers and agents must use only WHA CMS-approved materials including flyers and call scripts.

CMS Marketing Material Highlights

Websites

Third-party websites operated by agencies/agents that market and/or contain information about WHA MAPD products must meet applicable Medicare Communications and Marketing Guidelines (MCMG) requirements.

Websites must be submitted to WHA for review and approval.

CMS Marketing Material Highlights

Approvals

When making presentations, agents must rely upon the WHA CMS-approved Summary of Benefits, formulary, pharmacy and provider directories, and other plan documentation to address specific needs of each prospective member.

Materials must be pre-approved by CMS and Western Health Advantage:

- Printed with relevant approval/tracking codes
- Printed in (minimum) Times New Roman 12-point equivalent font

CMS Marketing Material Highlights

- If an agent/broker's phone number is listed on materials, then the WHA's Medicare Advantage customer service phone and TTY numbers should also be included
- Materials that include an agent/broker's phone number should clearly indicate "calling agent/broker number will direct an individual to a licensed agent/broker"

Marketing Support

To support agent sales activities during the Annual Enrollment Period (AEP), WHA has made available:

- Customizable flyers
- Mailers
- Promotional items
- Sales materials
- Event sponsorships

CMS Sales/Marketing Event Highlights

- Sales/Marketing events are designed to steer, or attempt to steer, potential enrollees toward a plan or a limited set of plans
- At Sales/Marketing events you can promote premiums, benefits offered by the plan, as well as accept enrollment forms

CMS Sales/Marketing Event Highlights

At a Sales/Marketing event, you may:

- Distribute WHA CMS-approved marketing materials
- Assist with and accept enrollment applications
- Review benefit information using the approved sales presentation

CMS Sales/Marketing Event Highlights

At a Sales/Marketing event, you may not:

- Be late or absent from an event reported to the plan
- Require beneficiaries to provide any contact information
- Solicit or accept any enrollment applications for the AEP prior to October 15, 2023
- Provide meals to attendees, including subsidized meals
- Conduct health screening activities
- Use unsubstantiated absolute superlative (e.g. “rated number 1”) or qualified superlatives such as “one of the best”

Educational Events

Educational events are designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs.

- Materials distributed or made available must be free of plan-specific information, including premium and copays
- Marketing materials and/or enrollment applications are prohibited
- It must be explicitly advertised as “educational,” otherwise it will be considered a Sales/Marketing event
- It must be held in public venues and cannot occur in a one-on-one setting

Educational Events

Agents and brokers must report all events to the plan prior to advertising.

- Report modifications or cancellations to the plan immediately
- Notify beneficiaries of cancellations or modifications by the same means to advertise the event
- If an approved event date must be changed to a future month, that event must be cancelled in the online reporting tool and reentered as new event for the future month

Phone Contacts & Personal Appointments

Phone Contacts

Prohibited telephonic activities include, but are not limited to, the following:

- Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (the plan must have documentation of permission to be contacted)
- Calls based on referrals: if an individual would like to refer a friend or relative to an agent or plan, the agent or plan may provide contact information such as a business card that the individual may give to a friend or relative

Phone Contacts & Personal Appointments

Scope of Appointment (SOA)

SOA guidelines were established to ensure MAPD plan sponsors do not market any health care related product, beyond the scope that was agreed upon by the beneficiary, and documented by the plan, prior to a face-to-face or telephonic marketing appointment.

- The documentation must be in writing, in the form of a signed and dated agreement by the beneficiary, or recorded oral agreement
- Use the most current SOA form provided by the plan associated with the enrollment
- Another carrier's SOA form may be used, as long as it is CMS approved

Phone Contacts & Personal Appointments

Scope of Appointment (SOA)

All agents and brokers are responsible to complete the SOA per CMS guidelines.

- The Plan/Part D Sponsor must document the scope of the agreement
- “Walk-ins” require a signed scope of appointment before discussing Medicare Advantage or PDP plans AND must indicate “walk-in” on form

CMS Record Retention Requirements

- All plan sponsors and contracted downstream entities must abide by CMS rules and regulations regarding record retention by retaining documents (i.e. books, records) for a period of ten (10) years
- Plan sponsors are responsible for ensuring any marketing materials developed on behalf of the plan or by third party or delegated entities adhere to CMS record retention requirements
- Any records which should be retained as a result of direction from the Department of Justice should be kept by plan sponsors and their affiliates

Violations and Agents

- Violations of CMS Sales & Marketing standards will be investigated and may result in disciplinary action
- Allegations from beneficiaries against agents will be investigated and may result in disciplinary action
- Direct violations of CMS prohibited practices may result in termination of Western Health Advantage brokers and agents, along with reporting to CMS and the state licensing board for possible further disciplinary action, up to and including loss of license

Common Sales Allegations

- Provides incorrect cost-sharing amounts for prescription drugs
- Provides incorrect provider affiliation information
- Provides inaccurate or incomplete information on services that require a pre-service referral/authorization
- Beneficiary indicates they did not enroll in the plan
- Beneficiary indicates they did not receive general information on how a Medicare HMO works

Common Deficiencies Noted by CMS

- Agent requires attendees to provide contact information
- Sign-in sheet was not identified as optional to complete
- Information on Plan Ratings was not provided or fully discussed
- Agent did not explain where to find information on covered prescription drugs and explanation of prior authorization process (e.g., step therapy)

Common Deficiencies Noted by CMS

- Sales Event did not occur and was not reported as cancelled
  - Agents must notify WHA at least 7 calendar days in advance of event
  - Notice of an event change must be at least 48 hours prior to the event
- A full meal was offered or served; only snacks are allowed (e.g., cookies or pastries, cheese and crackers, or fruit)

Safeguarding Protected Health Information (PHI)

Best Practices

- CALL — Discuss beneficiary information by phone
- FAX — Verify the fax number before sending beneficiary information via a fax machine
- MAIL — Use registered mail to ensure delivery of beneficiary documents
- EMAIL — Must be encrypted and/or attachments must be password protected
- IN-PERSON — Personal delivery by the agent of beneficiary documents (ask for a signature confirming delivery)

Reporting Compliance, Privacy, and Fraud & Abuse

Compliance

To report compliance violations or have compliance questions, send an email to WHA's Medicare Compliance Officer, Jessica Warshaw at j.warshaw@westernhealth.com.

General compliance inquiries can be submitted to medicarecompliance@westernhealth.com.

Reporting Compliance, Privacy, and Fraud & Abuse

Suspected Privacy Incidents

To report incidents or breaches to WHA as required under regulations and the Business Associate Agreement, send an email to privacy@westernhealth.com.

To make any other notifications of security incidents, send an email to informationsecurity@westernhealth.com. If the notification includes PHI, the information must be sent securely, such as in an encrypted attachment, with the decryption key communicated by phone, fax or in a separate password-protected email.

Reporting Compliance, Privacy, and Fraud & Abuse

Fraud & Abuse

Contact the WHA Compliance and Ethics Hotline at 833.310.0007 or send an email to lighthouse-services.com/westernhealth.com.

Understanding an HMO

Primary Care Physicians

WHA is an HMO. An HMO requires its members to select a primary care physician (PCP) within their network. This is the doctor that a member will see whenever he or she needs medical care.

Members are encouraged to select a PCP at the time of enrollment otherwise, WHA assigns a PCP to the member. Members can change their PCP throughout the year, if needed.

In the event a member needs specialty care, the PCP will refer the member to a specialist within his or her network.

Understanding an HMO

Specialty Care Options

WHA members have choices for specialty care referrals beyond their PCP's medical group. WHA's Advantage Referral program provides access to specialists outside of the member's affiliated medical group. A member can ask their PCP to see any specialist participating in the program. Some limitations apply.

Gynecological services and annual eye exams are included in the Advantage Referral program. These services do not require a PCP referral or authorization, as long as the specialist participates in Advantage Referral.

Understanding an HMO

Behavioral Health

Mental health and substance abuse services are available to WHA members without a PCP referral through the health plan's behavioral network of providers.

Types of behavioral health services include: Inpatient care, outpatient care, psychiatric evaluation, office and telehealth visits, and substance abuse treatment.

Extensive Provider Search

Members can use WHA's provider search to find a full listing of primary and specialty care doctors, hospitals, pharmacies and urgent care centers in their area. Use filters to fully customize a search, such as:

- Name
- Provider type and/or specialty;
- Accepting new patients
- Languages spoken
- Distance from a specified location
- Gender
- Hospital and/or medical group affiliation
- Panel status
- Effective date

Telehealth Services

Telehealth services can include doctor-patient interactions via:

- Telephone call
- Web-based portal
- Smartphone app
- Other video service

When a WHA network provider offers telehealth services, members will have the same cost-sharing that they would have for an office visit. Members should refer to their plan documents for cost-sharing amounts.

Prescriptions

WHA offers Medicare Advantage Prescription Drug (MAPD) Plans, which are health plans that also cover Part D prescription drugs.

WHA offers its members options for obtaining covered prescriptions:

- Network retail Pharmacies (including Preferred Pharmacies for greater cost savings)
- Mail-order program
- Specialty pharmacy

Prescriptions filled at out-of-network pharmacies are covered if the prescription is related to care for a medical emergency or urgently needed care.

Prescriptions

There are generally four benefit phases associated with a Medicare Part D plan:

- Deductible
- Initial Coverage
- Coverage Gap
- Catastrophic Coverage

Prescriptions

The amount a member pays for a prescription depends on:

- The coverage phase
- Type of drug and its applicable cost-sharing tier
- If the prescription is obtained at a network pharmacy or mail order
- The days' supply (e.g. 30-day, 90-day)

Formulary Tiers

A formulary is a list of drugs covered by the plan. Covered drugs fall into particular categories to determine the member cost-share.

- Preferred generic
- Generic
- Preferred brand
- Non-preferred drugs
- Specialty tier

Agents must confirm drug coverage with the beneficiary if they have specific medication concerns. Formulary drug lists are different by MAPD plan.

Formulary Tiers

WHA's formulary includes coverage limits on certain drugs. Coverage limits are also called "drug utilization management tools."

- A team of doctors and pharmacists develop these utilization management tools
- These tools protect members, control over-utilization, and guard against unnecessary spending
- These tools are used for high-cost or high-risk drugs

Formulary Tiers

WHA may periodically add, remove or make changes to coverage limitations on certain drugs or change how much the member pays for a drug.

WHA will inform members prior to making any negative formulary changes during the contract year and is required to have a transition process for new beneficiaries to allow time for them change to a different medication on WHA's formulary, if medically necessary.

Drug Exceptions

The exception process usually occurs when a member submits a request to WHA to make a decision on whether to cover a drug or to allow a lower member cost-share for a formulary drug.

Drug Exceptions

There are forms of drug exceptions, an exception request may include a request for benefits, a request for payment, or both:

- Formulary exceptions allow a member to obtain a Medicare covered prescription drug that is not on WHA's formulary
- Tiering exceptions* are when a member requests to obtain a Medicare covered prescription drug at a more favorable cost-sharing level

continued

*Drugs in our Tiers 1 and 5 are not eligible for tier exceptions. We do not lower the cost-sharing amount for drugs in these tiers.

Drug Exceptions

There are forms of drug exceptions, an exception request may include a request for benefits, a request for payment, or both:

- Utilization restriction exceptions are when a member requests WHA to waive restrictions for a Medicare covered prescription drug (For Example: Step Therapy, Quantity Limits, Prior Authorization)

Formulary exceptions are not guaranteed and should not be presented to prospects as such.

*Drugs in our Tiers 1 and 5 are not eligible for tier exceptions. We do not lower the cost-sharing amount for drugs in these tiers.

Filing Coverage Determination & Exceptions

- The request for coverage determination or exception can be requested by the member, their doctor or other prescriber, or their designated representative
- It can be filed as standard or an expedited request
- The standard request requires a plan decision within 72 hours of receipt of request
- The expedited request requires a plan decision within 24 hours of receipt of request
- Coverage determinations and exception requests can be filed in writing, through electronic prior authorization, or by calling Western Health Advantage

Drug Utilization Management

WHA's formulary includes limits on certain drugs. Coverage limits are also called, "drug utilization management tools."

- A team of doctors and pharmacists develop these utilization management tools
- These tools protect members, control over-utilization, and guard against unnecessary spending
- Often, these tools are used for high-cost or high-risk drugs

Examples of utilization management tools are Prior Authorization, Quantity Limits, Step Therapy, and Generic Substitution.

Drug Utilization Management

Prior Authorization

Members are required to get prior authorization for certain drugs as indicated in the formulary. This means that members or their authorized representative must get approval from WHA before filling a prescription. If they don't get approval, WHA may not cover the drug.

Drug Utilization Management

Quantity Limits

For certain drugs, WHA limits the amount of the drug that is covered per prescription or for a defined period of time. These drugs are defined on the formulary.

Drug Utilization Management

Quantity Limits

In some cases, WHA requires members to first try certain drugs to treat a medical condition before WHA will cover another drug for that condition.

For example, if drug A and drug B both treat a certain medical condition, WHA may require the member's doctor to prescribe drug A first. If drug A does not work, then WHA will cover drug B.

Drug Utilization Management

Generic Substitution

When there is a generic version of a brand-name drug available, WHA's network pharmacies will automatically give the member the generic version, unless the member's doctor specifically states that the member must take the brand-name drug. This request should be indicated on the written prescription or phoned into the pharmacy.

In some cases the brand-name drug may require Prior Authorization.

Complaints

- Complaints are any expression of dissatisfaction to WHA or a provider, facility or Quality Improvement Organization (QIO) by a member, either verbally or in writing
- Members have the right to make a complaint if they have concerns or problems related to their coverage or care
- Sales Agents/Brokers should encourage members to let WHA know right away if they have questions, concerns, or problems related to their covered services or the care received
- Appeals and grievances are the two different types of complaints a member can make

Appeals

An appeal is a complaint made by a member if they disagree with the health plan's decision to deny a request for coverage of health care services or prescription drugs, or payment for services or drugs they already received. The member can also make an appeal if they disagree with the Plan sponsor's decision to stop services they are receiving.

Appeals

A member might fight an appeal when WHA:

- Refuses to cover or pay for services the member believes should be covered
- Or a WHA provider refuses to provide a service the member believes should be covered
- Or a WHA provider reduces or cuts back on services or benefits the member has been receiving
- Is stopping coverage of a service or benefit, and the member believes it is too soon to do so
- Refuses to reimburse the member for the drugs paid for out-of-pocket
- Has miscalculated the member's true out-of-pocket amount

Appeals Process

A member, or his/her authorized representative or provider, must submit the request for an appeal within 60 calendar days of the date of denial notice. The request can only be made by phone (for an expedited request) or in writing (for a standard request).

A member, or his/her authorized representative or provider, can ask the Plan verbally rather than in writing to give an expedited “fast” decision, rather than a “standard” decision for services that have not been received.

Appeals Process

Plan response times, from receipt of appeal:

- For a decision about payment for medical care the member has already received, WHA has 60 days
- For the standard decision for medical care or services the member has not yet received. WHA has 30 days
- For an expedited decision about services the member has not yet received, WHA has 72 hours

continued

Appeals Process

Plan response times, from receipt of appeal:

- For a standard decision about a Part D drug that includes a request to reimburse the member for a Part D drug they have already paid for and received, WHA has 7 calendar days
- For an expedited decision about a Part D drug the member has not yet received, WHA has 72 hours

Initial Decision or Organization Determination

This is the starting point. If the initial decision is to deny the request (in whole or part), then an appeal can be made.

Appeals Process

There are five levels of appeals:

- Appeal or request for reconsideration
- Independent Review Entity (IRE) contracted by CMS
- Administrative Law Judge Hearing (the amount of controversy must meet a minimum standard as defined by CMS)
- Medicare Appeals Council (MAC) Review
- Judicial Review (the amount in controversy must meet a minimum standard as defined by CMS)

Grievances

A grievance is any communication, verbal or written, from a member expressing dissatisfaction with any aspect of the Medicare Advantage plan or any contracted provider's activities or behavior regardless of whether any remedial action is requested.

Grievances

Reasons a member might file a grievance may include:

- Quality of care
- Wait times for scheduling appointments or time spent in the waiting room during appointments
- The way the doctor(s) or other staff behaved
- Not being able to reach someone by phone or get information needed
- The cleanliness or condition of the doctor’s office or pharmacy

Medicare Enrollment Process and Requirements

Pre-Enrollment Checklist

Prior to making an enrollment decision, beneficiaries must review and complete the pre-enrollment checklist.

This checklist is included in the Summary of Benefits and is an acknowledgement of the beneficiary's full understanding of plan benefits and rules prior to enrollment.

Medicare Enrollment Process and Requirements

Completing an Enrollment Application

- Each Medicare beneficiary or his/her authorized representative must sign and date his/her own enrollment form (a spouse cannot sign for a husband/wife)
- All enrollment fields must be completed
    - If the field does not apply, such as a request for an email address, mark N/A

Medicare Enrollment Process and Requirements

Completing an Enrollment Application

The Medicare identification number should be written on the enrollment application exactly as it appears on the red, white and blue Medicare card.

- Agents must see the beneficiary's Medicare card to verify the spelling of beneficiary's full name and Part A and Part B effective dates, and to indicate these on the application
- The sales Agent/Broker may complete or accept enrollment forms with future effective dates ONLY for beneficiaries who are "Aging in" (i.e., turning 65 years old within the next three months)

Medicare Enrollment Process and Requirements

Completing an Enrollment Application

Make certain the applicant's permanent address is in the service area of the plan that the beneficiary has selected. An application for a beneficiary who does not live in the plan's service area will be denied.

- A post office box may be used as a mailing address but NOT as a permanent address
- Note: Western Health Advantage contracts with the Centers for Medicare & Medicaid Services (CMS) to serve Medicare beneficiaries in the following service areas: Marin, Napa, Sacramento, Solano, Sonoma, and Yolo counties

Medicare Enrollment Process and Requirements

Completing an Enrollment Application

The sales agent/broker may complete or accept enrollment forms with future effective dates ONLY for beneficiaries who are “Aging in” (i.e., turning 65 years old within the next three months).

Medicare Enrollment Process and Requirements

Completing an Enrollment Application

Agents should have the Medicare beneficiary initial any mistakes or changes on an enrollment form at the point of sale.

- An agent/broker may make corrections to a completed application prior to submission as long as the agent/broker initials and dates the change
- An agent/broker cannot correct the beneficiary's signature or date of signature

Medicare Enrollment Process and Requirements

Completing an Enrollment Application

Prior to signing the enrollment application, the agent should review plan information to ensure the prospective member is making an informed choice.

The agent should:

- Verify the beneficiary is eligible to enroll and has a qualifying election period
- Review and confirm the beneficiary's existing coverage (including a Medicare Advantage plan) to ensure proper plan selection
- Verify the application is signed and dated

Medicare Enrollment Process and Requirements

The agent should:

- Inform the beneficiary they will receive an Outbound Enrollment Verification (OEV) letter
- The agent must submit the application immediately via fax, overnight mail or online
- The application date is the date the agent or broker receives the enrollment request
- If a beneficiary requests that you hold his/her application, you must explain that you can either submit or cancel the application following established procedures

Medicare Enrollment Process and Requirements

Be sure to transmit all pages of the application, including any necessary supporting documentation.

Agents must submit completed enrollment applications to WHA within 24 hours of the agent's signature.

During the last week of an enrollment period, all enrollment forms must be submitted on a daily basis.

Medicare Enrollment Process and Requirements

Upon receiving an enrollment request, a Medicare Organization must provide within:

- 15 days: Enrollment Verification letter
- 10 days: Notice of Denial
- 15 days: Acknowledgment notice

Timeframes for requests for additional information will vary.

Medicare Enrollment Process and Requirements

Effective Date

With the exception of some SEPs and other circumstances, a beneficiary cannot request an enrollment effective date. The plan will use the selected election period to determine the effective date.

Generally, with the exception of AEP, most of the applications received in the current month will be effective the first of the following month.

- Important to remember: no retroactive effectives will be issued and the plan effective date cannot be prior to Medicare Part A and Part B entitlement

Medicare Enrollment Process and Requirements

Enrollment applications, sales flyers and brochures requests:

medicaresales@westernhealth.com or 916.246.7494 or 888.992.7494 toll-free

Submit enrollment applications:

A) DocuSign

B) Secure email: MAenrollment@westernhealth.com

C) Fax: 916.678.5441

D) Mail enrollment forms to: Western Health Advantage Mail Service
Attn: Membership Accounting
PO Box 14952
Salem, OR 97309

2024 Western Health Advantage Medicare Advantage Service Area

In **Marin, Napa, Sacramento, Solano, Sonoma, and Yolo counties**, WHA offers Medicare beneficiaries an option to enroll in MyCare (HMO).

In **Humboldt County**, WHA offers Medicare beneficiaries an option to enroll in MyCare Compass (HMO).

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2024 WHA's Medicare Advantage (HMO) Benefit Comparison

Medical Copayments	Western Health Advantage MyCare (HMO)	Western Health Advantage MyCare Compass (HMO)
	Available in Marin, Napa, Sacramento, Solano, Sonoma, Yolo	*Available in Humboldt*
Monthly Plan Premium	**$0**	**$20**
Annual Part C Deductible	$0	$0
Annual Out-of-Pocket Max	$4,500	$4,500
PCP Visits	$0	$0
Specialist Visits	$25 copay	$25 copay
Lab Services	$0	$0
Emergency Care	$90	$90
Urgent Care	$25	$25
Hospital Care (inpatient)	$265/day (days 1-6, then $0)	$265/day (days 1-6, then $0)
Outpatient Surgery	$250	$250
Ambulance	$250	$250

2024 WHA's Medicare Advantage (HMO) Benefit Comparison

Prescription Copayments	Western Health Advantage MyCare (HMO)			Western Health Advantage MyCare Compass (HMO)		
	Available in Marin, Napa, Sacramento, Solano, Sonoma, Yolo			*Available in Humboldt*		
Monthly Plan Premium	**$0**			**$20**		
Annual Prescription Drug Deductible	$0			$0		
Prescription Supply	**1 month**	**2 months**	**3 months**	**1 month**	**2 months**	**3 months**
Tier 1: Preferred generic	$0	$0	$0	$0	$0	$0
Tier 2: Generic*	$5	$10	$15	$5	$10	$15
Tier 3: Preferred brand*	$40	$80	$120	$40	$80	$120
Tier 4: Non-preferred brand	$100	$200	$300	$100	$200	$300
Tier 5: Specialty	33%	33%	33%	33%	33%	33%
Tier 6: Vaccines	$0	N/A	N/A	$0	$0	$0

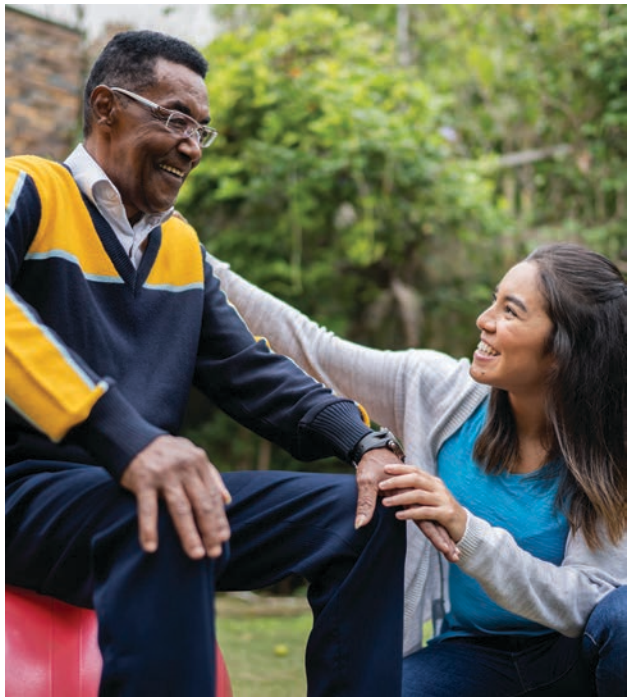
Value-added: In-home Support

Papa™ Pals is available with MyCare and MyCare Compass plans.

Papa Pals is a network of individuals that offers non-clinical support in the member's home.

These personal companions are background checked, trained and motivated to assist seniors with daily activities like transportation, companionship, household chores, technical assistance and exercise.

Visits available seven days a week and easily scheduled through an online care center or secure mobile app.



Value-added: OTC Allowance

Optum® Personal Care Benefits Essentials is available with MyCare and MyCare Compass plans.

Members receive credits each quarter to spend on over-the-counter products (like toothpaste, vitamins, pain relief and more). Orders are made easy via phone or online.

Value-added: Vision Care

MESVision® is available with MyCare and MyCare Compass plans.

Benefits include up to $100 for routine eye wear (contact lenses, eyeglass frames and/or eyeglass lenses) every two years.

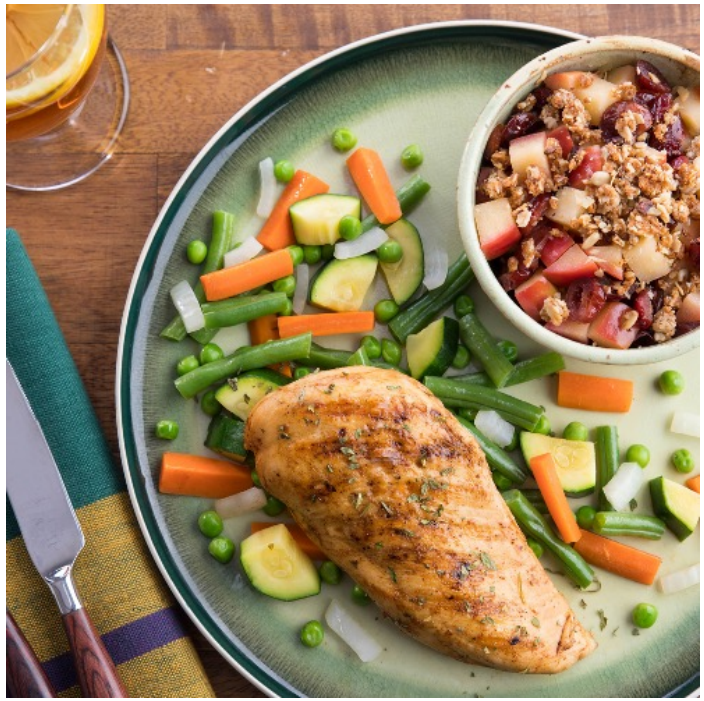
Annual eye exams are covered under your plan with a WHA participating provider; no PCP referral needed.

Value-added: Health Meal Services

Mom's Meals® is available with MyCare and MyCare Compass plans.

Following a hospital stay, members get a month's worth of meals delivered right to their doorstep.

Maximum of 56 after each discharge, up to four times per year.



Value-added: Fitness Program

Silver&Fit® is available with MyCare and MyCare Compass plans.

This flexible program is tailored to meet a member's unique needs through access to participating fitness center, digital workout videos, coaching sessions, and an activity tracking tool.

Participating locations available online.

Value-added: Alternative Medicine

Landmark Healthplan is available with MyCare and MyCare Compass plans.

Routine acupuncture and chiropractic benefits that may give a member hands-on treatment for improved wellness of low back pain, neck pain, headaches and much more.

Value-added: Health and Wellness

MyWHA Wellness is available with MyCare and MyCare Compass plans.

These wellness program components help members set personal health and wellness goals while providing easy tools to help them achieve those goals.

Value-added: Travel Assistance

Assist America is available with MyCare and MyCare Compass plans.

Connects members to qualified healthcare providers, hospitals, pharmacies and other services, in the event of an emergency while traveling more than 100 miles away home for up to 90 days.

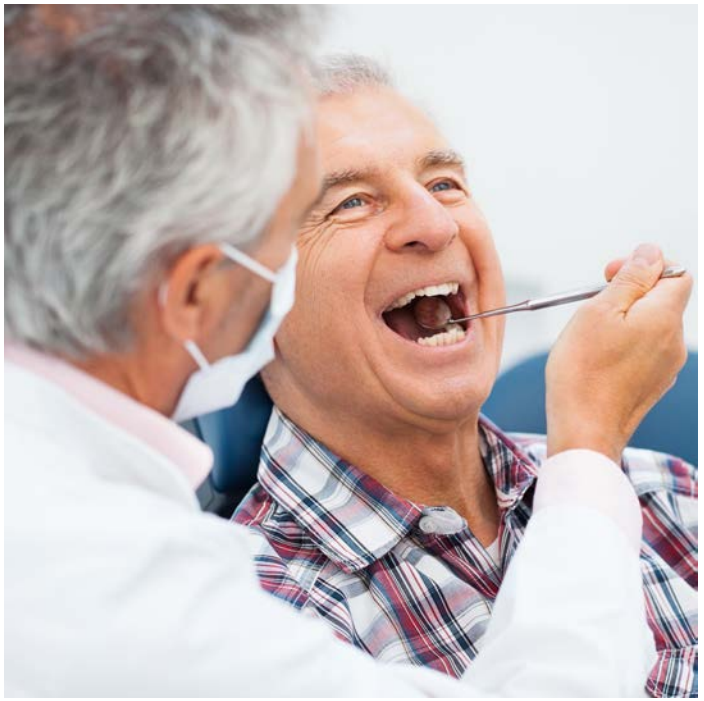
WHA plans cover emergency services and urgent care, in and out of the service area.

Value-added: Dental Care

DeltaCare® USA DHMO is available with MyCare plan.

Comprehensive dental coverage including:

- $0 copay
- Routine exams and cleanings
- X-rays twice a year



*Not available in Humboldt County

Value-added: Hearing Aids

TruHearing® is available with MyCare plan.

Comprehensive coverage includes two hearing aids per year ($699 Advanced model or $999 for Premium model) plus:

- Fitting, evaluation and follow-up visits
- Plus 80 free batteries per non-rechargeable hearing aid

Note: Annual hearing exams are covered under our plans with a WHA participating provider; no PCP referral needed.

*Not available in Humboldt County

Admin and Recap

The Nitty Gritty

- Order kits by visiting WHA's Medicare Marketing Materials portal
- Enrollments to WHA within 24 hours after receipt
- WHA sends outbound verification letter to new enrollees
- Durable power of attorney form is required when applicable
- Witness translator form is required when applicable

Congratulations!

You have completed the 2024 Certification Training for Western Health Advantage Medicare Advantage.

What's Next? **Click here for the WHA Agent Certification online test**

- Take the test and receive your score
- Receive and download your certificate
- You must pass the test with a minimum score of 85%
- You may take the test a maximum of three times