Western Health Advantage

2022 Summary of Benefits

Western Health Advantage MyCare Plus (HMO)

January 1, 2022 – December 31, 2022

This plan is available in Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties in Northern California.

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When you choose **Western Health Advantage MyCare Plus (HMO)**, you get a Medicare Advantage plan that supports your ongoing health and well-being. Western Health Advantage is a nonprofit HMO plan founded by doctors on the front lines of patient care. For over 20 years, we've been recognized for providing quality, affordable health care to Northern California residents. We offer exceptional care through a broad network of doctors and hospitals where over 100,000 members benefit from comprehensive personalized care. Our responsive support team is available to answer questions and ensure you get the care you need.

To help you make the right health care decisions, we're providing this summary of benefits that breaks down what we would cover and what you would pay if you joined Western Health Advantage MyCare Plus (HMO).

This booklet gives you a summary of what Western Health Advantage MyCare Plus (HMO) covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. For a complete list of services that we cover, please refer to the Evidence of Coverage (EOC). You can request a printed copy by visiting **mywha.org/MyCareEOC** or by calling our Member Services department at one of the numbers listed in the "Get in touch" section below.

Plan overview

Our plan members get all of the benefits covered by Original Medicare as well as some extra benefits outlined in this summary.

Who can join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes **Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties in Northern California**.

Get in touch

Questions? We're here to help seven days a week from 8 a.m. to 8 p.m.

- If you're a member of this plan, call us toll-free at 1.888.563.2250 (TTY 711)
- If you're not a member of this plan, call us toll-free at 1.888.992.7494 (TTY 711)
- You can also visit us online at **medicare.westernhealth.com**

Helpful resources

- Visit **mywha.org/MyCaredoctors** to see our plan's Provider and Pharmacy Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
- Want to see our plan's formulary (list of Part D prescription drugs), including any restrictions? Visit **mywha.org/MyCareDrugList**, or call us for a printed copy.
- To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, view it online at **www.Medicare.gov** or request a printed copy by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, seven days a week. TTY users should call 1.877.486.2048.

Western Health Advantage is an HMO plan with a Medicare contract. Enrollment in Western Health Advantage depends on contract renewal. This information is not a complete description of benefits. Western Health Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Medical Benefits

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Monthly Plan Premium		$99 In addition, you must continue to pay your Medicare Part B premium.
Deductible		$0 There is no yearly deductible for medical services.
Maximum Out-of-Pocket Responsibility		Your yearly limit(s) for this plan:
		In-network: $5,500
Benefits		**What You Pay**
Inpatient Hospital Coverage[1]		$175 copay per day for days 1-6 of a benefit period $0 copay per day for days 7-90 of a benefit period
Outpatient Hospital Coverage[1]		$200 copay for outpatient surgery at a hospital facility
Ambulatory Surgery Center[1]		$100 copay for outpatient surgery at an Ambulatory Surgery Center
Doctor Visits	Primary Care Provider visit	$0 copay
	Specialist visit[1,2]	$20 copay
Preventive Care		$0 copay
Emergency Care		$90 copay Copay is waived if you are admitted to the hospital within 24 hours for the same condition.
Urgently Needed Services		$20 copay Copay is waived if you are admitted to the hospital within 24 hours for the same condition.

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Medical Benefits

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Benefits		What You Pay
Diagnostic Services/ Labs/Imaging[1,2]	Diagnostic radiology services (e.g. MRI, ultrasounds, CT scans)	$50 copay per day
	Therapeutic radiology services	$50 copay per day
	Outpatient X-rays	$0 copay
	Diagnostic tests and procedures	$0 copay
	Lab services	$0 copay
Hearing Services[2]	Medicare-covered	$20 copay
	Routine hearing exams	$0 copay for 1 routine hearing exam every year with a TruHearing provider $0 copay for an unlimited number of hearing aid fitting and evaluation visits every year following the purchase of a hearing aid
	Hearing Aids	$699 copay per aid for an Advanced hearing aid; $999 copay per aid for a Premium hearing aid; Up to 2 TruHearing-branded hearing aids every year - one per ear per year; $50 additional cost per aid for optional hearing aid rechargeability
Dental Services[1]	Medicare-covered	$20 copay
	Preventive (supplemental)	$0 copay Includes exams, cleanings, X-rays, fluoride treatments; limits apply
	Comprehensive (supplemental)	$0 to $775 copay Includes diagnostic and restorative services, endodontics, periodontics, prosthodontics, extractions, and oral surgery; limits apply

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Benefits		What You Pay
Vision Services	Medicare-covered exams/screening	$20 copay per exam $0 copay for a glaucoma screening once per year
	Routine exam	$20 copay for 1 routine vision exam, including refraction, every year
	Medicare-covered eyewear	$20 copay
	Routine eyeglasses or contact lenses	Plan will pay up to $200 for routine eye wear (contact lenses, eyeglass frames and/or eyeglass lenses) every two years
Mental Health Services	Inpatient visit[1]	$175 copay per day for days 1-6 of a benefit period $0 copay per day for days 7-90 of a benefit period
	Outpatient individual and group therapy visit	$35 copay
Skilled Nursing Facility[1]		$0 copay per day for days 1-20; $150 copay per day for days 21-100 per benefit period; Inpatient hospital stay is not required prior to admission.
Physical therapy[1,2]		$0 copay
Ambulance[1]		$250 copay for each one-way transport
Non-emergent transportation		Not covered
Medicare Part B drugs[1]		20% of the contracted rate

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[2] Services may require a referral from your doctor.

Prescription Drug Benefits

Western Health Advantage MyCare Plus (HMO)

Prescription Drug Deductible	
Deductible	There is no yearly prescription drug deductible for this plan.

Initial Coverage	You pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.

Standard and Preferred Retail Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 90 days**
Tier 1 (Preferred Generic)	Standard: $0 copay Preferred: $0 copay	Standard: $0 copay Preferred: $0 copay	Standard: $0 copay Preferred: $0 copay
Tier 2 (Generic)*	Standard: $10 copay ($10 for Select Insulins) Preferred: $5 copay ($5 for Select Insulins)	Standard: $20 copay ($20 for Select Insulins) Preferred: $10 copay ($10 for Select Insulins)	Standard: $30 copay ($30 for Select Insulins) Preferred: $15 copay ($15 for Select Insulins)
Tier 3 (Preferred Brand)*	Standard: $45 copay ($35 for Select Insulins) Preferred: $35 copay ($35 for Select Insulins)	Standard: $90 copay ($70 for Select Insulins) Preferred: $70 copay ($70 for Select Insulins)	Standard: $135 copay ($105 for Select Insulins) Preferred: $105 copay ($105 for Select Insulins)
Tier 4 (Non-Preferred Drug)	Standard: $100 copay Preferred: $90 copay	Standard: $200 copay Preferred: $180 copay	Standard: $300 copay Preferred: $270 copay
Tier 5 (Specialty)	Standard: 33% of the total cost Preferred: 33% of the total cost	Not covered	Not covered

Prescription Drug Benefits

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	Up to 30 days	Up to 60 days	Up to 90 days
Tier 6 (Vaccines)	Standard: $0 copay Preferred: $0 copay	Not covered	Not covered

* The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump, then the insulin must be covered under Part B and will not be eligible for the Part D copays.

Mail-Order Cost Sharing

	Up to 30 days	Up to 60 days	Up to 90 days
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)*	$10 copay ($10 for Select Insulins)	$20 copay ($20 for Select Insulins)	$25 copay ($25 for Select Insulins)
Tier 3 (Preferred Brand)*	$45 copay ($35 for Select Insulins)	$90 copay ($70 for Select Insulins)	$112.50 copay ($105 for Select Insulins)
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$250 copay
Tier 5 (Specialty)	33% of the total cost	Not covered	Not covered
Tier 6 (Vaccines)	Mail order is not available for drugs in Tier 6.	Mail order is not available for drugs in Tier 6.	Mail order is not available for drugs in Tier 6.

* The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump, then the insulin must be covered under Part B and will not be eligible for the Part D copays.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy.

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Coverage Gap (Applies to all tiers)	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for the drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,430**. After you enter the coverage gap, for Tier 1 (Preferred Generic) drugs at a Preferred Retail Pharmacy you continue to pay your Tier 1 cost share, and at a Standard Retail Pharmacy you pay $5 for up to 30 days, $10 for up to 60 days, and $15 for up to 90 days. You continue to pay your Tier 6 cost share for Tier 6 (Vaccines) drugs, 25% of the plan's cost for the covered brand name drugs, and 25% of the plan's cost for other covered generic drugs until your costs total **$7,050**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Standard and Preferred Retail Cost Sharing

	Up to 30 days	**Up to 60 days**	**Up to 90 days**
Tier 1 (Preferred Generic)	Standard: $5 copay Preferred: $0 copay	Standard: $10 copay Preferred: $0 copay	Standard: $15 copay Preferred: $0 copay
Tier 2 (Generic)*	Standard: 25% of the total cost ($10 for Select Insulins) Preferred: 25% of the total cost ($5 for Select Insulins)	Standard: 25% of the total cost ($20 for Select Insulins) Preferred: 25% of the total cost ($10 for Select Insulins)	Standard: 25% of the total cost ($30 for Select Insulins) Preferred: 25% of the total cost ($15 for Select Insulins)
Tier 3 (Preferred Brand)*	Standard: 25% of the total cost ($35 for Select Insulins) Preferred: 25% of the total cost ($35 for Select Insulins)	Standard: 25% of the total cost ($70 for Select Insulins) Preferred: 25% of the total cost ($70 for Select Insulins)	Standard: 25% of the total cost ($105 for Select Insulins) Preferred: 25% of the total cost ($105 for Select Insulins)
Tier 4 (Non-Preferred Drug)	25% of the total cost	25% of the total cost	25% of the total cost
Tier 5 (Specialty)	25% of the total cost	Not covered	Not covered
Tier 6 (Vaccines)	Standard: $0 copay Preferred: $0 copay	Not covered	Not covered

Prescription Drug Benefits

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* The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump, then the insulin must be covered under Part B and will not be eligible for the Part D copays.

Mail-Order Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 90 days**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)*	25% of the total cost ($10 for Select Insulins)	25% of the total cost ($20 for Select Insulins)	25% of the total cost ($25 for Select Insulins)
Tier 3 (Preferred Brand)*	25% of the total cost ($35 for Select Insulins)	25% of the total cost ($70 for Select Insulins)	25% of the total cost ($105 for Select Insulins)
Tier 4 (Non-Preferred Drug)	25% of the total cost	25% of the total cost	25% of the total cost
Tier 5 (Specialty)	25% of the total cost	Not covered	Not covered
Tier 6 (Vaccines)	Mail order is not available for drugs in Tier 6.	Mail order is not available for drugs in Tier 6.	Mail order is not available for drugs in Tier 6.

* The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump, then the insulin must be covered under Part B and will not be eligible for the Part D copays.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy.

Catastrophic Coverage (Applies to all tiers)	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the greater of: 5% of the cost or $3.95 copayment for generic (including brand drugs treated as generic) or a $9.85 copayment for all other drugs.

Medical Benefits

Western Health Advantage MyCare Plus (HMO)

Benefits (continued)	What You Pay
Annual physical exam	$0 copay
Durable Medical Equipment[1]	20% of the contracted rate
Fitness benefit	$0 copay for access to a variety of fitness centers, virtual coaching and on-line resources through Silver&Fit.
Meals	$0 copay for 2 meals per day for 4 weeks immediately following discharge from a skilled nursing facility, hospital, or rehabilitation center. Total maximum of 56 meals after each discharge for up to 4 times per year.
Over-the-Counter items	Plan covers up to $100 every three months. Unused portions do not carry over to the next quarter.
Routine chiropractic and acupuncture services	$20 copay for up to 20 routine visits each year (routine chiropractic and acupuncture services combined)

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.