COMMUNITY HEALTH PLAN of Washington™

The power of community

MEDICARE ADVANTAGE

Community Health Plan of Washington Medicare Advantage

HMO Plans: **Plan 1 | Plan 2 | Plan 3 | Plan 4 | Freedom Plan**

2024 Summary of Benefits

Get ***More Than*** Original Medicare

CHPW Medicare Advantage Plan 1 (HMO)

Service areas: Clallam, Clark, Cowlitz, Jefferson, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Yakima.

CHPW Medicare Advantage Plan 1 (HMO)
Summary of Premiums & Benefits

Monthly Plan Premium	$0 per month In addition, you must keep paying your Medicare Part B Premium.
Deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: $8,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost of your Part D prescription drugs.
Inpatient Hospital	Our plan covers an unlimited number of days for an inpatient hospital stay. · $500 copay per day for days 1 through 4 for each benefit period · $0 copay days 5 through 90 for each benefit period Each new benefit period begins with a new day 1
Outpatient Hospital	$370 copay for Medicare-covered outpatient hospital observation services. $370 copay for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center	$370 copay

CHPW Medicare Advantage Plan 1 (HMO)
Summary of Premiums & Benefits

Doctor Visits[1,2]
(Primary care and Specialists)

Primary care physician visit*:
$0 copay

Specialist visit*:
$50 copay

*Including telehealth visits

Preventive Care[2]

$0 copay for preventive services, such as flu shots, and yearly "Wellness" visits

Any additional preventive services approved by Medicare during the contract year will be covered. Eight counseling calls per year and Nicotine Replacement Therapy of up to 12 weeks are also available. Please call for more details.

Emergency Care

$100 copay

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See "Inpatient Hospital Care" section of this booklet for other costs.

Urgently Needed Services

$40 copay for Medicare-covered urgently-needed care visits.

Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

If additional services are provided, cost sharing may apply. For urgently needed services received outside of the U.S. and its territories, please see "Worldwide emergency/urgent care."

Diagnostic Services/ Labs/Imaging[1]

Diagnostic radiology services *(such as MRIs, CT scans)*:
20% of the cost

Lab services:
$0 copay

Diagnostic tests and procedures:
20% of the cost

Outpatient X-rays:
$15 copay

Therapeutic radiology services, such as radiation treatment for cancer:
20% of the cost

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

Hearing Services[1,2] 	Medicare-covered diagnostic hearing exams: 20% of the cost Routine hearing exams and hearing aids are not covered.
Dental Services[1] 	Two preventive visits per year. You must use a dentist who is part of Delta Dental of Washington's dental network. To find the most current listing of Delta Dental PPO Plus Premier network dentists, visit DeltaDentalWA.com. Delta Dental Network Providers must submit claims for these dental services to Delta Dental of Washington. You will be responsible for all, or most, services provided by Out of Network dentists.
Vision Services 	**Vision services:** 20% of the cost for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. **Vision services (supplemental):** · Not covered **Outside of the VSP Choice network:** · 100% of the cost over the plan benefit limit.
Mental Health Services[1,2] 	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For Medicare-covered inpatient psychiatric hospital stays: · $350 copay per day for days 1 through 5 · $0 copay per day for days 6 through 90 **Outpatient group and/or individual therapy visit (including telehealth):** $40 copay *If additional services are provided, cost sharing may apply.*

Skilled Nursing Facility (SNF)1,2 	Our plan covers up to 100 days in a SNF. · $0 copay per day for days 1 through 20 for each benefit period · $200 copay per day for days 21 through 100 for each benefit period
Physical Therapy 	$50 copay for outpatient services
Ambulance[1] 	$350 copay for one-way, Medicare-covered ambulance benefits.
Medicare Part B Drugs 	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost *For part D drug coverage please see the next section.*

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

Medicare Part D Drugs Deductible $230 - Tier 5 Specialty Drugs only. No deductible for Tiers 1-4.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Stage 1: Deductible Stage	During this stage, you pay the full cost of your Tier 5 drugs. You stay in this stage until you have paid $230 for your Tier 5 drugs. There is no deductible for Tier 1-4 drugs.
Stage 2: Initial Coverage	You pay the cost share for Tier 1, Tier 2, Tier 3, Tier 4, and Tier 5 Part D prescription drug until your yearly drug costs reach $5,030. Total yearly drug costs are the total drug cost paid by you and Part D plan.
Stage 3: Coverage Gap	After your total drug costs reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during that coverage gap between the True-Out-Of-Pocket (TrOOP) costs $5,030 to $8,000.
Stage 4: Catastrophic Coverage	After your yearly our-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay the greater of: · 5% coinsurance, or · $4.15 copay for generic (including brand drugs treated as generic) or $10.35 copay for all other drugs.

Retail cost sharing	Preferred Pharmacy		Standard Pharmacy	
Tier	30 Day supply	90 Day supply	30 Day supply	90 Day supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$10 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$37 copay	$110 copay	$47 copay	$140 copay
Tier 4: Non-preferred Drug	50% of the cost	50% of the cost	50% of the cost	50% of the cost
Tier 5: Speciality Tier	29% of the cost	Not covered	29% of the cost	Not covered

Preferred Mail Order Cost-Sharing

Tier	90 Day supply
Tier 1: Preferred Generic	$0 copay
Tier 2: Generic	$20 copay
Tier 3: Preferred Brand	$110 copay

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

CHPW Medicare Advantage Plan 1 (HMO)
Summary of Other Benefits

Health & Wellbeing 	$0 copay for covered services which include acupuncture, naturopathy, and routine chiropractic with up to 12 sessions or visits on all service types combined per year. *These services must be performed by a state certified practitioner.*
Telehealth Services 	**We cover telehealth services, including virtual visits with:** · Primary care provider · Specialist · Urgent Care · Individual and group sessions for outpatient mental health, psychiatric, and substance abuse You pay the same as you would for an in-person visit.
Diabetic Supplies/ Diabetes Supplies and Services 	$0 for the cost of Medicare-covered diabetic self-management, diabetes services and supplies. Diabetic medication, such as insulin, injected by syringe is typically covered by your Part D prescription drug coverage.
Durable Medical Equipment [1] 	20% of the cost for Medicare-covered durable medical equipment.

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

Fitness Program 	$0 copay for the following: · Home fitness kit (options include activity tracker, videos, and exercise equipment) · Membership at a participating fitness center · Online and smartphone fitness app tools
Foot Care[1,2] (podiatry services) 	**Podiatry Services:** $20 copay for each Medicare-covered podiatry visit. Covered services include: · Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) · Routine foot care for members with certain medical conditions affecting the lower limbs. **Podiatry Services (supplemental):** $0 of the cost for each supplemental podiatry visit. Our supplemental benefit includes up to four (4) visits per year for non-Medicare covered foot care from a Medicare-approved foot care provider.
Home Health Care[1,2] 	$0 copay for Medicare-covered home health visits.
Hospice 	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Community Health Plan of Washington Medicare Advantage.
Meals When You Need It Most 	You pay nothing for covered meals up to the maximum benefit. Benefit includes 28 meals post discharge from each hospital or skilled nursing facility admission. Also available with a positive COVID-19 diagnosis. Meal program limited to 6 instances per calendar year.

CHPW Medicare Advantage Plan 1 (HMO)
Summary of Other Benefits

Outpatient Substance Abuse[1,2] 	**Group therapy visit:** 20% of the cost	**Individual therapy visit:** 20% of the cost
Prosthetic Devices[1] (Braces, artificial limbs, etc.) 	**Medicare-covered:** **Prosthetic Devices** 20% of the cost	**Medical Supplies** 20% of the cost
Renal Dialysis[1] 	20% of the cost	
Worldwide Emergency/ Urgent Care 	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000 per year. This plan covers supplemental emergency services, urgent services, and emergency transportation received outside of the U.S. and its territories up to a plan coverage limit. This does not apply to the Maximum Out-of-Pocket responsibility.	
Family on Demand 	Family on Demand, offered by CHPW through Papa Pals, pairs you with members of your community for an extra pair of hands, a shoulder to lean on, and a listening ear. You get 60 hours of Family on Demand per year–for help with errands or meal prep, simple tech support, or just a little company.	

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

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CHPW Medicare Advantage Plan 2 (HMO)

Service areas: Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Douglas, Franklin, Grant, Jefferson, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Yakima.

CHPW Medicare Advantage Plan 2 (HMO)
Summary of Premiums & Benefits

Monthly Plan Premium	$0 - $38.40 (exact amount depends on level of Extra Help) In addition, you must keep paying your Medicare Part B Premium.
Deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: $8,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost of your Part D prescription drugs.
Inpatient Hospital	Our plan covers an unlimited number of days for an inpatient hospital stay. · $500 copay per day for days 1 through 4 for each benefit period · $0 copay days 5 through 90 for each benefit period Each new benefit period begins with a new day 1
Outpatient Hospital	$365 copay for Medicare-covered outpatient hospital observation services. $365 copay for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center	$365 copay

CHPW Medicare Advantage Plan 2 (HMO)
Summary of Premiums & Benefits

Doctor Visits[1,2] (Primary care and Specialists) 	**Primary care physician visit*:** $0 copay **Specialist visit*:** $50 copay *Including telehealth visits
Preventive Care[2] 	$0 copay for preventive services, such as flu shots, and yearly "Wellness" visits Any additional preventive services approved by Medicare during the contract year will be covered. Eight counseling calls per year and Nicotine Replacement Therapy of up to 12 weeks are also available. Please call for more details.
Emergency Care 	$100 copay If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services 	$40 copay for Medicare-covered urgently-needed care visits. Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary. If additional services are provided, cost sharing may apply. For urgently needed services received outside of the U.S. and its territories, please see "Worldwide emergency/urgent care."
Diagnostic Services/ Labs/Imaging[1] 	**Diagnostic radiology services** *(such as MRIs, CT scans)*: 20% of the cost **Lab services:** $0 copay **Diagnostic tests and procedures:** 20% of the cost **Outpatient X-rays:** $15 copay **Therapeutic radiology services, such as radiation treatment for cancer:** 20% of the cost

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

Hearing Services[1,2] 	Medicare-covered diagnostic hearing exams: 20% of the cost Routine hearing exams and hearing aids are not covered.
Dental Services[1] 	$0 copay for unlimited supplemental preventive services. $0 copay for supplemental comprehensive services, up to $500 per year. You pay nothing for unlimited preventive services. You also pay nothing for supplemental comprehensive services, up to a $500 total benefit limit per year. You must use a dentist who is part of Delta Dental of Washington's dental network. To find the most current listing of Delta Dental PPO Plus Premier network dentists, visit DeltaDentalWA.com. Delta Dental Network Providers must submit claims for these dental services to Delta Dental of Washington. You will be responsible for all, or most, services provided by Out of Network dentists.
Vision Services 	**Vision services:** 20% of the cost for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. **Vision services (supplemental):** Not covered **Outside of the VSP Choice network:** · 100% of the cost over the plan benefit limit.
Mental Health Services[1,2] 	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For Medicare-covered inpatient psychiatric hospital stays: · $350 copay per day for days 1 through 5 · $0 copay per day for days 6 through 90 **Outpatient group and/or individual therapy visit (including telehealth):** $40 copay *If additional services are provided, cost sharing may apply.*

Skilled Nursing Facility (SNF)1,2 	Our plan covers up to 100 days in a SNF. · $0 copay per day for days 1 through 20 for each benefit period · $200 copay per day for days 21 through 100 for each benefit period
Physical Therapy 	$45 copay for each Medicare covered outpatient visit
Ambulance[1] 	$350 copay for one-way, Medicare-covered ambulance benefits.
Medicare Part B Drugs 	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost *For part D drug coverage please see the next section.*

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

Medicare Part D Drugs Deductible No Deductible

You may get your drugs at network retail pharmacies and mail order pharmacies.

Stage 1: Initial Coverage	You pay the cost share for Tier 1, Tier 2, Tier 3, Tier 4, and Tier 5 Part D prescription drug until your yearly drug costs reach $5,030. Total yearly drug costs are the total drug cost paid by you and Part D plan.
Stage 2: Coverage Gap	After your total drug costs reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during that coverage gap between the True-Out-Of-Pocket (TrOOP) costs $5,030 to $8,000.
Stage 3: Catastrophic Coverage	After your yearly our-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000,, you pay the greater of: · 5% coinsurance, or · $4.15 copay for generic (including brand drugs treated as generic) or $10.35 copay for all other drugs.

Retail cost sharing	Preferred Pharmacy		Standard Pharmacy	
Tier	30 Day supply	90 Day supply	30 Day supply	90 Day supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$10 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$37 copay	$110 copay	$47 copay	$140 copay
Tier 4: Non-preferred Drug	50% of the cost	50% of the cost	50% of the cost	50% of the cost
Tier 5: Speciality Tier	33% of the cost	Not covered	33% of the cost	Not covered

Preferred Mail Order Cost-Sharing

Tier	90 Day supply
Tier 1: Preferred Generic	$0 copay
Tier 2: Generic	$20 copay
Tier 3: Preferred Brand	$110 copay

Note: Depending on your level of "Extra Help" subsidy, your pharmacy cost-shares may be reduced

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

CHPW Medicare Advantage Plan 2 (HMO)
Summary of Other Benefits

Health & Wellbeing 	$0 copay for covered services which include acupuncture, naturopathy, routine chiropractic, massage therapy, and CHPW-recommended wellbeing programs with up to 25 sessions or visits on all service types combined per year. *These services must be performed by a state certified practitioner.*
Telehealth Services 	**We cover telehealth services, including virtual visits with:** · Primary care provider · Specialist · Urgent Care · Individual and group sessions for outpatient mental health, psychiatric, and substance abuse You pay the same as you would for an in-person visit.
Diabetic Supplies/ Diabetes Supplies and Services 	$0 for the cost of Medicare-covered diabetic self-management, diabetes services and supplies. Diabetic medication, such as insulin, injected by syringe is typically covered by your Part D prescription drug coverage.
Durable Medical Equipment [1] 	20% of the cost for Medicare-covered durable medical equipment.

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

Fitness Program 	**$0 copay for the following:** · Home fitness kit (options include activity tracker, videos, and exercise equipment) · Membership at a participating fitness center · Online and smartphone fitness app tools
Foot Care[1,2] (podiatry services) 	**Podiatry Services:** $0 copay for each Medicare-covered podiatry visit. Covered services include: · Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) · Routine foot care for members with certain medical conditions affecting the lower limbs. **Podiatry Services (supplemental):** $0 of the cost for each supplemental podiatry visit. Our supplemental benefit includes up to four (4) visits per year for non-Medicare covered foot care from a Medicare-approved foot care provider.
Home Health Care[1,2] 	$0 copay for Medicare-covered home health visits.
Hospice 	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Community Health Plan of Washington Medicare Advantage.

CHPW Medicare Advantage Plan 2 (HMO)
Summary of Other Benefits

Meals When You Need It Most

You pay nothing for covered meals up to the maximum benefit.

Benefit includes 28 meals post discharge from each hospital or skilled nursing facility admission. Also available with a positive COVID-19 diagnosis. Meal program limited to 6 instances per calendar year.

Outpatient Substance Abuse[1,2]

Group therapy visit:
20% of the cost

Individual therapy visit:
20% of the cost

Prosthetic Devices[1]
(Braces, artificial limbs, etc.)

Medicare-covered:

Prosthetic Devices
20% of the cost

Medical Supplies
20% of the cost

Renal Dialysis[1]

20% of the cost

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

Worldwide Emergency/ Urgent Care 	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000 per year. This plan covers supplemental emergency services, urgent services, and emergency transportation received outside of the U.S. and its territories up to a plan coverage limit. This does not apply to the Maximum Out-of-Pocket responsibility.
Family on Demand 	Family on Demand, offered by CHPW through Papa Pals, pairs you with members of your community for an extra pair of hands, a shoulder to lean on, and a listening ear. You get 60 hours of Family on Demand per year--for help with errands or meal prep, simple tech support, or just a little company.

CHPW Medicare Advantage Plans 3 & 4 (HMO)

Plan 3 service areas: Clark, Cowlitz, King, Kitsap, Pierce, Snohomish, Spokane, Thurston.

Plan 4 service areas: Adams, Chelan, Douglas, Grant, Lewis, Okanogan, Skagit, Walla Walla, Whatcom, Yakima.

CHPW Medicare Advantage Plans 3 & 4 (HMO)
Summary of Premiums & Benefits

Monthly Plan Premium 	**Plan 3** $79 per month	**Plan 4** $105 per month
	In addition, you must keep paying your Medicare Part B Premium.	
Deductible	This plan does not have a deductible	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs) 	Your yearly limit(s) in this plan: $8,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost of your Part D prescription drugs.	
Inpatient Hospital 	Our plan covers an unlimited number of days for an inpatient hospital stay. · $500 copay per day for days 1 through 4 for each benefit period · $0 copay days 5 through 90 for each benefit period Each new benefit period begins with a new day 1	
Outpatient Hospital 	$325 copay for Medicare-covered outpatient hospital observation services. $325 copay for Medicare-covered outpatient hospital surgery and other services.	
Ambulatory Surgery Center 	$325 copay	

Doctor Visits[1,2] (Primary care and Specialists) 	**Primary care physician visit*:** $0 copay **Specialist visit*:** $40 copay *Including telehealth visits
Preventive Care[2] 	$0 copay for preventive services, such as flu shots, and yearly "Wellness" visits Any additional preventive services approved by Medicare during the contract year will be covered. Eight counseling calls per year and Nicotine Replacement Therapy of up to 12 weeks are also available. Please call for more details.
Emergency Care 	$100 copay If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services 	$0 copay for Medicare-covered urgently-needed care visits. Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary. If additional services are provided, cost sharing may apply. For urgently needed services received outside of the U.S. and its territories, please see "Worldwide emergency/urgent care."
Diagnostic Services/ Labs/Imaging[1] 	**Diagnostic radiology services** *(such as MRIs, CT scans)*: 20% of the cost **Lab services:** $0 copay **Diagnostic tests and procedures:** 20% of the cost **Outpatient X-rays:** $15 copay **Therapeutic radiology services, such as radiation treatment for cancer:** 20% of the cost

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

Hearing Services[1,2] 	Medicare-covered diagnostic hearing exams: $20 copay Routine hearing exams and hearing aids are not covered.
Dental Services[1] 	$0 copay for unlimited supplemental preventive services. $0 copay for supplemental comprehensive services, up to $500 per year. You pay nothing for unlimited preventive services. You also pay nothing for supplemental comprehensive services, up to a $500 total benefit limit per year. You must use a dentist who is part of Delta Dental of Washington's dental network. To find the most current listing of Delta Dental PPO Plus Premier network dentists, visit DeltaDentalWA.com. Delta Dental Network Providers must submit claims for these dental services to Delta Dental of Washington. You will be responsible for all, or most, services provided by Out of Network dentists.
Vision Services 	**Vision services:** $40 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. **Vision services (supplemental):** *(Through the Vision Service Plan (VSP) Choice Network)* · $0 copay for one WellVision exam every year · Up to $150 benefit limit every two years for supplemental vision hardware. **Outside of the VSP Choice network:** · 100% of the cost over the plan benefit limit.
Mental Health Services[1,2] 	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For Medicare-covered inpatient psychiatric hospital stays: · $175 copay per day for days 1 through 10 · $0 copay per day for days 11 through 90 **Outpatient group and/or individual therapy visit (including telehealth):** $30 copay *If additional services are provided, cost sharing may apply.*

Skilled Nursing Facility (SNF)1,2 	Our plan covers up to 100 days in a SNF. · $0 copay per day for days 1 through 20 for each benefit period · $200 copay per day for days 21 through 100 for each benefit period
Physical Therapy 	$30 copay for outpatient services
Ambulance[1] 	$325 copay for one-way, Medicare-covered ambulance benefits.
Medicare Part B Drugs 	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost *For part D drug coverage please see the next section.*

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

Medicare Part D Drugs Deductible No Deductible

You may get your drugs at network retail pharmacies and mail order pharmacies.

Stage 1: Initial Coverage	You pay the cost share for Tier 1, Tier 2, Tier 3, Tier 4, and Tier 5 Part D prescription drug until your yearly drug costs reach $5,030. Total yearly drug costs are the total drug cost paid by you and Part D plan.
Stage 2: Coverage Gap	After your total drug costs reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during that coverage gap between the True-Out-Of-Pocket (TrOOP) costs $5,030 to $8,000.
Stage 3: Catastrophic Coverage	After your yearly our-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay the greater of: · 5% coinsurance, or · $4.15 copay for generic (including brand drugs treated as generic) or $10.35 copay for all other drugs.

Retail cost sharing	Preferred Pharmacy		Standard Pharmacy	
Tier	30 Day supply	90 Day supply	30 Day supply	90 Day supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$10 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$37 copay	$110 copay	$47 copay	$140 copay
Tier 4: Non-preferred Drug	50% of the cost	50% of the cost	50% of the cost	50% of the cost
Tier 5: Speciality Tier	33% of the cost	Not covered	33% of the cost	Not covered

Preferred Mail Order Cost-Sharing

Tier	90 Day supply
Tier 1: Preferred Generic	$0 copay
Tier 2: Generic	$20 copay
Tier 3: Preferred Brand	$110 copay

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

CHPW Medicare Advantage Plans 3 & 4 (HMO)
Summary of Other Benefits

Health & Wellbeing

$0 copay for covered services which include acupuncture, naturopathy, and routine chiropractic with up to 12 sessions or visits on all service types combined per year.

These services must be performed by a state certified practitioner.

Telehealth Services

We cover telehealth services, including virtual visits with:

- Primary care provider
- Specialist
- Urgent Care
- Individual and group sessions for outpatient mental health, psychiatric, and substance abuse

You pay the same as you would for an in-person visit.

Diabetic Supplies/ Diabetes Supplies and Services

$0 for the cost of Medicare-covered diabetic self-management, diabetes services and supplies. Diabetic medication, such as insulin, injected by syringe is typically covered by your Part D prescription drug coverage.

Durable Medical Equipment [1]

20% of the cost for Medicare-covered durable medical equipment.

Fitness Program

$0 copay for the following:

- Home fitness kit (options include activity tracker, videos, and exercise equipment)
- Membership at a participating fitness center
- Online and smartphone fitness app tools

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

Foot Care[1,2] (podiatry services) 	**Podiatry Services:** $0 copay for each Medicare-covered podiatry visit. Covered services include: · Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) · Routine foot care for members with certain medical conditions affecting the lower limbs. **Podiatry Services (supplemental):** $0 copay for each supplemental podiatry visit. Our supplemental benefit includes up to four (4) visits per year for non-Medicare covered foot care from a Medicare-approved foot care provider.
Home Health Care[1,2] 	$0 copay for Medicare-covered home health visits.
Hospice 	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Community Health Plan of Washington Medicare Advantage.
Meals When You Need It Most 	You pay nothing for covered meals up to the maximum benefit. Benefit includes 28 meals post discharge from each hospital or skilled nursing facility admission. Also available with a positive COVID-19 diagnosis. Meal program limited to 6 instances per calendar year.

Outpatient Substance Abuse[1,2]	**Group therapy visit:** 20% of the cost	**Individual therapy visit:** 20% of the cost
Prosthetic Devices[1] (Braces, artificial limbs, etc.)	**Medicare-covered:** **Prosthetic Devices** 20% of the cost	**Medical Supplies** 20% of the cost
Renal Dialysis[1]	20% of the cost	
Worldwide Emergency/ Urgent Care	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000 per year. This plan covers supplemental emergency services, urgent services, and emergency transportation received outside of the U.S. and its territories up to a plan coverage limit. This does not apply to the Maximum Out-of-Pocket responsibility.	

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

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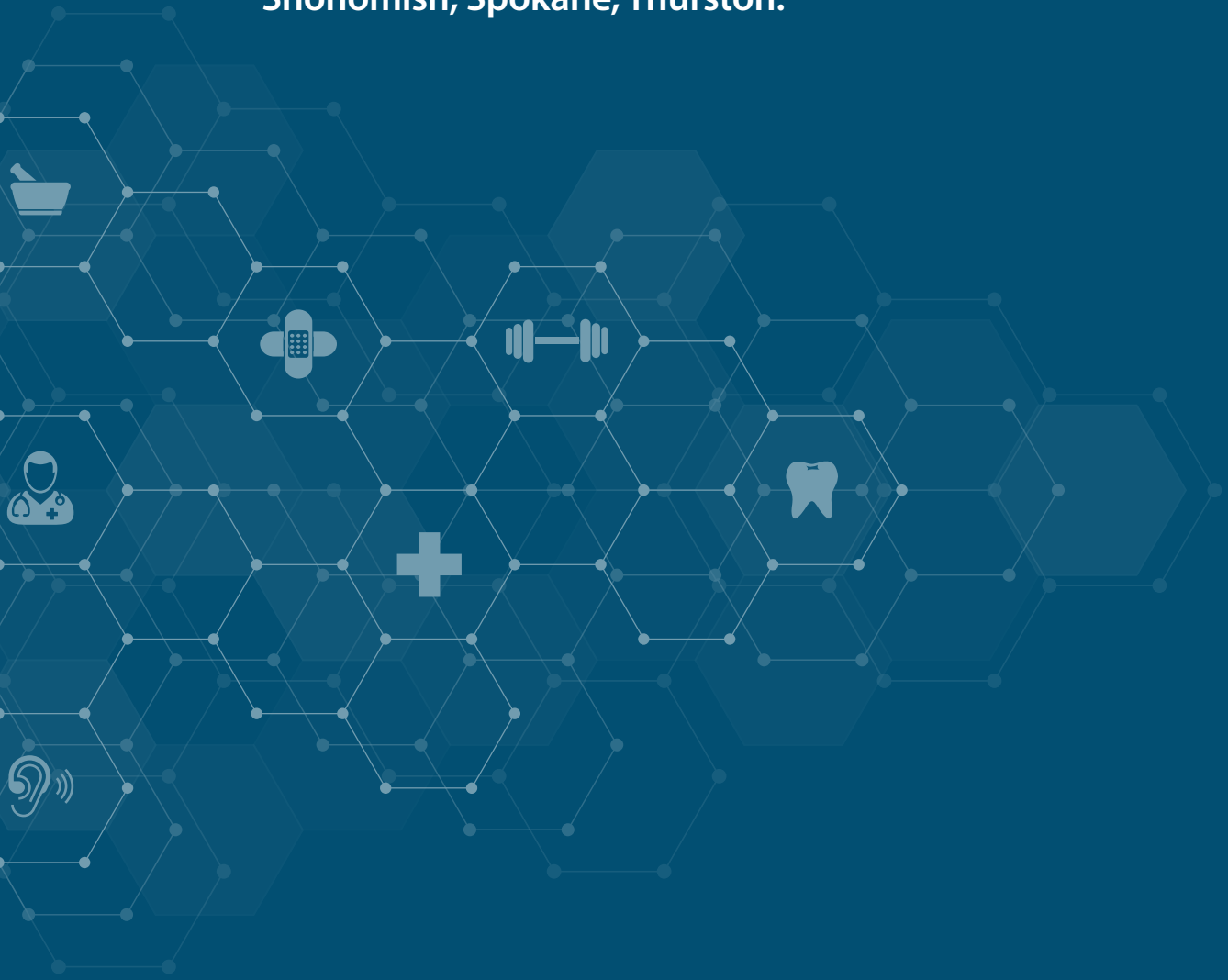
CHPW Medicare Advantage Freedom Plan (HMO)

Service areas: Clark, Cowlitz, King, Kitsap, Pierce, Snohomish, Spokane, Thurston.



CHPW Medicare Advantage Freedom Plan (HMO)
Summary of Premiums & Benefits

Monthly Plan Premium	$0 per month In addition, you must keep paying your Medicare Part B Premium.
Deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: $8,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost of your Part D prescription drugs.
Inpatient Hospital	Our plan covers an unlimited number of days for an inpatient hospital stay. · $500 copay per day for days 1 through 4 for each benefit period · $0 copay days 5 through 90 for each benefit period Each new benefit period begins with a new day 1
Outpatient Hospital	$250 copay for Medicare-covered outpatient hospital observation services. $250 copay for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center	$250 copay

Doctor Visits[1,2] (Primary care and Specialists) 	**Primary care physician visit*:** $0 copay **Specialist visit*:** $40 copay *Including telehealth visits
Preventive Care[2] 	$0 copay for preventive services, such as flu shots, and yearly "Wellness" visits Any additional preventive services approved by Medicare during the contract year will be covered. Eight counseling calls per year and Nicotine Replacement Therapy of up to 12 weeks are also available. Please call for more details.
Emergency Care 	$100 copay If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services 	$0 copay for Medicare-covered urgently-needed care visits. Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary. If additional services are provided, cost sharing may apply. For urgently needed services received outside of the U.S. and its territories, please see "Worldwide emergency/urgent care."

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

Diagnostic Services/ Labs/Imaging[1] 	**Diagnostic radiology services** *(such as MRIs, CT scans)*: 20% of the cost **Lab services:** $0 copay	**Diagnostic tests and procedures:** 20% of the cost **Outpatient X-rays:** $15 copay
	Therapeutic radiology services, such as radiation treatment for cancer: 20% of the cost	
Hearing Services[1,2] 	Medicare-covered diagnostic hearing exams: $20 copay Routine hearing exams and hearing aids are not covered.	
Dental Services[1] 	$0 copay for unlimited supplemental preventive services. $0 copay for supplemental comprehensive services, up to $500 per year. You pay nothing for unlimited preventive services. You also pay nothing for supplemental comprehensive services, up to a $500 total benefit limit per year. You must use a dentist who is part of Delta Dental of Washington's dental network. To find the most current listing of Delta Dental PPO Plus Premier network dentists, visit DeltaDentalWA.com. Delta Dental Network Providers must submit claims for these dental services to Delta Dental of Washington. You will be responsible for all, or most, services provided by Out of Network dentists.	
Vision Services 	**Vision services:** $40 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. **Vision services (supplemental):** *(Through the Vision Service Plan (VSP) Choice Network)* · $0 copay for one WellVision exam every year · Up to $150 benefit limit every two years for supplemental vision hardware. **Outside of the VSP Choice network:** · 100% of the cost over the plan benefit limit.	

Mental Health Services[1,2] 	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For Medicare-covered inpatient psychiatric hospital stays: · $175 copay per day for days 1 through 10 · $0 copay per day for days 11 through 90 **Outpatient group and/or individual therapy visit (including telehealth):** $30 copay *If additional services are provided, cost sharing may apply.*
Skilled Nursing Facility (SNF)1,2 	Our plan covers up to 100 days in a SNF. · $0 copay per day for days 1 through 20 for each benefit period · $200 copay per day for days 21 through 100 for each benefit period
Physical Therapy 	$30 copay for outpatient services
Ambulance[1] 	$300 copay for one-way, Medicare-covered ambulance benefits.
Medicare Part B Drugs 	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost *For part D drug coverage please see the next section.*
Medicare Part D Drugs	This plan does not cover Part D prescription drugs

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

Health & Wellbeing 	$0 copay for covered services which include acupuncture, naturopathy, and routine chiropractic with up to 12 sessions or visits on all service types combined per year. *These services must be performed by a state certified practitioner.*
Telehealth Services 	**We cover telehealth services, including virtual visits with:** · Primary care provider · Specialist · Urgent Care · Individual and group sessions for outpatient mental health, psychiatric, and substance abuse You pay the same as you would for an in-person visit.
Diabetic Supplies/ Diabetes Supplies and Services 	$0 for the cost of Medicare-covered diabetic self-management, diabetes services and supplies. Diabetic medication, such as insulin, injected by syringe is typically covered by your Part D prescription drug coverage.
Durable Medical Equipment [1] 	20% of the cost for Medicare-covered durable medical equipment.
Fitness Program 	**$0 copay for the following:** · Home fitness kit (options include activity tracker, videos, and exercise equipment) · Membership at a participating fitness center · Online and smartphone fitness app tools

CHPW Medicare Advantage Freedom Plan (HMO)
Summary of Other Benefits

Foot Care[1,2] (podiatry services) 	**Podiatry Services:** $0 copay for each Medicare-covered podiatry visit. Covered services include: · Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) · Routine foot care for members with certain medical conditions affecting the lower limbs. **Podiatry Services (supplemental):** $0 of the cost for each supplemental podiatry visit. Our supplemental benefit includes up to four (4) visits per year for non-Medicare covered foot care from a Medicare-approved foot care provider.	
Home Health Care[1,2] 	$0 copay for Medicare-covered home health visits.	
Hospice 	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Community Health Plan of Washington Medicare Advantage.	
Meals When You Need It Most 	You pay nothing for covered meals up to the maximum benefit. Benefit includes 28 meals post discharge from each hospital or skilled nursing facility admission. Also available with a positive COVID-19 diagnosis. Meal program limited to 6 instances per calendar year.	
Outpatient Substance Abuse[1,2] 	**Group therapy visit:** 20% of the cost	**Individual therapy visit:** 20% of the cost

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

Prosthetic Devices[1] (Braces, artificial limbs, etc.) 	**Medicare-covered:** **Prosthetic Devices** 20% of the cost	**Medical Supplies** 20% of the cost
Renal Dialysis[1] 	20% of the cost	
Worldwide Emergency/ Urgent Care 	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000 per year. This plan covers supplemental emergency services, urgent services, and emergency transportation received outside of the U.S. and its territories up to a plan coverage limit. This does not apply to the Maximum Out-of-Pocket responsibility.	

Non-Discrimination Notice

Community Health Plan of Washington complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Plan of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Under Washington law, people have a right to be free from discrimination because of race, creed, color, national origin, sex, veteran or military status, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a person with a disability.

Community Health Plan of Washington:

- Provides free assistance and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Customer Service (1-800-942-0247).

If you believe that Community Health Plan of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Appeals and Grievances Department, by mail at 1111 3rd Avenue, Suite 400, Seattle WA 98101, by phone at 1-800-942-0247 (TTY: 711), by fax at 206-613-8984, or by email at appealsgrievances@chpw.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language, at no additional cost.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-942-0247 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-942-0247 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-942-0247 (TTY: 711).

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-942-0247 (TTY: 711)。

Af Soomaali (Somali) DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqadda, oo lacag la'aan ah, ayaa laguu heli karaa adiga. Wac 1-800-942-0247. (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-942-0247 (телетайп: 711).

(Arabic) العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-942-0247 (طابعة هاتفية :711).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-942-0247 (መስማት ለተሳናቸው: 711).

توجه برای دری (Dari) اگر به زبان دری صحبت می کنید، خدمات مساعدت زبان، طور رایگان برای شما موجود می باشد. با شماره(711 :TTY) 1-800-942-0247 تماس بگیرید.

ትግርኛ (Tigrinya) ምልክታ፡ ትግርኛ ትዛረብ ተኸይንካ ኣገልግሎት ሓገዝ ቋንቋ ንዓኻ ብናጻ ይርከብ። ደውል 1-800-942-0247 (TTY: 711)።

ဗမာ (Burmese) သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-800-942-0247 (TTY: 711) သုိ႔ ေခၚဆိုပါ။

ਪੰਜਾਬੀ (Panjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-942-0247 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-800-942-0247 (TTY: 711) 번으로 전화해 주십시오.

(Farsi) فارسی توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-942-0247 (TTY: 711) تماس بگیرید.

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-942-0247 (телетайп: 711).

ភាសាខ្មែរ (Khmer) កត់ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាមិនគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរសព្ទមកលេខ 1-800-942-0247 (TTY: 711)។

Notes

Notes

Web:
medicare.chpw.org

Mailing Address:
Community Health Plan
of Washington
1111 3rd Ave, Suite 400
Seattle, WA 98101-3207

Prospective Members:
1-800-944-1247

Current Members:
1-800-942-0247

TTY: 711

8:00 a.m. to 8:00 p.m.
7 days a week

COMMUNITY HEALTH PLAN
of Washington™
MEDICARE ADVANTAGE

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