2023
Summary of Benefits

South Carolina

Wellcare No Premium (HMO)

H4847 | 001

Wellcare Assist (HMO)

H4847 | 005

Wellcare Patriot Giveback (HMO-POS)

H4847 | 006

We know how important it is to have a health plan you can count on.

This is a summary of drug and health services covered by Wellcare No Premium (HMO), Wellcare Assist (HMO) and Wellcare Patriot Giveback (HMO-POS) from January 1, 2023 to December 31, 2023.

This booklet will provide you with a summary of what we cover and the cost-sharing responsibilities. It does not list every service, limitation, or exclusion. A complete list of services can be found in the plan's Evidence of Coverage (EOC). You can find the Evidence of Coverage on our website at www.wellcare.com/medicare. To request a copy, please call 1-844-917-0175 (TTY 711): Hours are Monday - Sunday, 8 am - 8 pm (all time zones).

Who can join?

To enroll in one of our plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party. To be eligible, the beneficiary must also be a United States citizen or are lawfully present in the United States.

Our plans and service areas:
H4847001000 Wellcare No Premium (HMO) includes these counties in South Carolina: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, and York.

H4847005000 Wellcare Assist (HMO) includes these counties in South Carolina: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, and York.

H4847006000 Wellcare Patriot Giveback (HMO-POS) includes these counties in South Carolina: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, and York.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Health Maintenance Organizations (HMOs) are health care plans offered by an insurance provider with a network of contracted healthcare providers and facilities. HMOs generally require members to select a primary care provider (PCP) to coordinate care and if you need a specialist, the PCP will choose one who is

also in our network.

Health Maintenance Organizations-Point of Service (HMO-POS) plans are HMOs which, under certain circumstances, allow members to get care out-of-network, often at a higher cost-share than those provided from in-network providers. Out-of-network providers may choose not to bill our plan and may ask you to pay for services up front. If this happens, you can fill out a claim form and submit it to us with a copy of the bill and any documentation you have about payments you have made. Out-of-network/non-contracted providers are under no obligation to treat Wellcare Patriot Giveback (HMO-POS) plan members, except in emergency situations. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Our plans give you access to our network of highly skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. You can ask for a current provider and pharmacy directory or, for an up-to-date list of network providers, visit www.wellcare.com/medicare. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor our plan will be responsible for the costs.)

Our plans also include prescription drug coverage and access to our large network of pharmacies. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. Our plans use a formulary. Our drug plans are designed specifically for Medicare beneficiaries and include a comprehensive selection of affordable generic and brand name drugs.

Which doctors, hospitals and pharmacies can I use? Wellcare No Premium (HMO), Wellcare Assist (HMO) and Wellcare Patriot Giveback (HMO-POS) have a network of doctors, hospitals, pharmacies, and other providers. You can save money by using our preferred mail-order pharmacy and by using providers in the plan's network. With some plans if you use providers that are not in our network, your share of the costs for covered services may be higher.

You can see our plan's provider and pharmacy directory and for plans with prescription drug coverage, our complete plan Formulary (list of Part D prescription drugs) on our website at www.wellcare.com/medicare.

For more information, please call us at 1-844-917-0175 (TTY users should call 711). Hours are Monday - Sunday, 8 am - 8 pm (all time zones). Visit us at www.wellcare.com/medicare.

We must provide information in a way that works for you (in languages other than English, in audio, in braille, in large print, or other alternate formats, etc.). Please call Member Services if you need plan information in another format.

Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Service Area	**Our plans and service areas:** **H4847001000 Wellcare No Premium (HMO)** includes these counties in South Carolina: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, and York. **H4847005000 Wellcare Assist (HMO)** includes these counties in South Carolina: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, and York. **H4847006000 Wellcare Patriot Giveback (HMO-POS)** includes these counties in South Carolina: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, and York.		

Services with an asterisk (*) may require prior authorization.
Services with a square (▪) means a referral may be required.

Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Monthly plan premium (includes both medical and drugs)	$0 You must continue to pay your Medicare Part B premium.	$14.90 You must continue to pay your Medicare Part B premium.	$0 Plan does not cover Part D. You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	Not available	Not available	This plan offers a $60 give back every month in your Social Security check.
Deductible	No deductible	No deductible for medical. See prescription drugs section for Part D deductible.	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$5,200 annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.	$6,500 annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.	$7,550 in-network annually $7,550 combined in and out-of-network annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Inpatient Hospital coverage	**In-Network** For each admission, you pay: • $400 copay per day for days 1 through 5 • $0 copay per day for days 6 through 90 * **Out-of-Network** Days 1-90: 30% coinsurance per admission. *	**In-Network** For each admission, you pay: • $325 copay per day for days 1 through 6 • $0 copay per day for days 7 through 90 * **Out-of-Network** Days 1-90: 30% coinsurance per admission. *	**In-Network** For each admission, you pay: • $350 copay per day for days 1 through 5 • $0 copay per day for days 6 through 90 * **Out-of-Network** Days 1-90: 30% coinsurance per admission. *
Outpatient Hospital coverage Outpatient hospital services	**In-Network** $300 copay per non-surgical service $350 copay per surgical service * **Out-of-Network** 30% coinsurance for surgical and non-surgical services *	**In-Network** $200 copay per non-surgical service $300 copay per surgical service * **Out-of-Network** 30% coinsurance for surgical and non-surgical services *	**In-Network** $300 copay per non-surgical service $400 copay per surgical service * **Out-of-Network** 30% coinsurance for surgical and non-surgical services *

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	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Outpatient hospital observation services	**In-Network** $110 copay for outpatient observation services when you enter observation status through an emergency room. $350 copay for outpatient observation services when you enter observation status through an outpatient facility. *	**In-Network** $95 copay for outpatient observation services when you enter observation status through an emergency room. $300 copay for outpatient observation services when you enter observation status through an outpatient facility. *	**In-Network** $95 copay for outpatient observation services when you enter observation status through an emergency room. $400 copay for outpatient observation services when you enter observation status through an outpatient facility. * **Out-of-Network** 30% coinsurance *
Ambulatory surgical center (ASC) services	**In-Network** $250 copay *	**In-Network** $175 copay *	**In-Network** $250 copay * **Out-of-Network** 30% coinsurance *
Doctor Visits Primary Care Providers	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Specialists	**In-Network** $45 copay *	**In-Network** $25 copay *	**In-Network** $50 copay * **Out-of-Network** 30% coinsurance *
Preventive Care (e.g., Annual Wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular screenings, Cervical and vaginal cancer screening, Colorectal cancer screenings, Diabetes screenings, Hepatitis B Virus Screening, Prostate cancer screenings (PSA), Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots))	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *
Emergency care	$110 copay Copay is waived if you are admitted to a hospital within 24 hours.	$95 copay Copay is waived if you are admitted to a hospital within 24 hours.	$95 copay Copay is waived if you are admitted to a hospital within 24 hours.

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Worldwide emergency coverage	$110 copay Worldwide emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for worldwide emergency services.	$95 copay Worldwide emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for worldwide emergency services.	$95 copay Worldwide emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for worldwide emergency services.
Urgently needed services	$55 copay Copay is waived if you are admitted to a hospital within 24 hours.	$30 copay Copay is waived if you are admitted to a hospital within 24 hours.	$35 copay Copay is waived if you are admitted to a hospital within 24 hours.

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Worldwide urgent care coverage	$110 copay Worldwide emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for worldwide urgently needed services.	$95 copay Worldwide emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for worldwide urgently needed services.	$95 copay Worldwide emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for worldwide urgently needed services.
Diagnostic Services/Labs/Imaging Lab services	COVID-19 testing and specified testing-related services at any location are $0. **In-Network** $0 copay *	COVID-19 testing and specified testing-related services at any location are $0. **In-Network** $0 copay *	COVID-19 testing and specified testing-related services at any location are $0. **In-Network** $0 copay * **Out-of-Network** 30% coinsurance *

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	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Diagnostic tests and procedures	**In-Network** $0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. $0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. $100 copay for all other Medicare-covered diagnostic procedures and tests. *	**In-Network** $0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. $0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. $50 copay for all other Medicare-covered diagnostic procedures and tests. *	**In-Network** $0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. $0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. $100 copay for all other Medicare-covered diagnostic procedures and tests. * **Out-of-Network** 30% coinsurance *
Outpatient X-rays	**In-Network** $0 copay *	**In-Network** $0 copay *	**In-Network** $0 copay * **Out-of-Network** 30% coinsurance *

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Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** $0 copay for a Diagnostic Mammogram. $300 copay for all other diagnostic radiology services. *	**In-Network** $0 copay for a Diagnostic Mammogram. $200 copay for all other diagnostic radiology services. *	**In-Network** $0 copay for a Diagnostic Mammogram. $150 copay for diagnostic radiology services at all other locations. $300 copay for diagnostic radiology services received in an outpatient setting. * **Out-of-Network** 30% coinsurance *
Therapeutic Radiology	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 30% coinsurance *

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Hearing services Hearing Exam Medicare Covered	**In-Network** $45 copay ▪ *	**In-Network** $25 copay ▪ *	**In-Network** $50 copay ▪ * **Out-of-Network** 30% coinsurance *
Routine hearing exam	**In-Network** $0 copay ▪ * 1 exam every year	**In-Network** $0 copay ▪ * 1 exam every year	**In-Network** $0 copay ▪ * **Out-of-Network** Not covered 1 exam every year

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Hearing Aids			
Hearing Aid Fitting/Evaluation(s)	**In-Network** $0 copay ▪ * 1 fitting(s) / evaluation(s) every year	**In-Network** $0 copay ▪ * 1 fitting(s) / evaluation(s) every year	**In-Network** $0 copay ▪ * **Out-of-Network** Not covered 1 fitting(s) / evaluation(s) every year
Hearing aid allowance	Up to a $350 allowance per ear every year for hearing aids.	Up to a $750 allowance per ear every year for hearing aids.	Up to a $1,000 allowance per ear every year for hearing aids.
All types	**In-Network** $0 copay ▪ * Limited to 2 hearing aid(s) every year	**In-Network** $0 copay ▪ * Limited to 2 hearing aid(s) every year	**In-Network** $0 copay ▪ * **Out-of-Network** Not covered Limited to 2 hearing aid(s) every year

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Additional Hearing Information	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.
Dental services			
Preventive services	**In-Network** $0 copay * Cleanings 2 every year Dental x-rays 1 every 12 to 36 months depending on type of service Oral exams 2 every year	**In-Network** $0 copay * Cleanings 2 every year Dental x-rays 1 every 12 to 36 months depending on type of service Oral exams 2 every year	**In-Network** $0 copay * **Out-of-Network** Not covered Cleanings 2 every year Dental x-rays 1 every 12 to 36 months depending on type of service Oral exams 2 every year

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Fluoride Treatment	**In-Network** $0 copay * 1 every year	**In-Network** $0 copay * 1 every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 every year
Comprehensive services Medicare-covered	**In-Network** $45 copay for each Medicare-covered service. *	**In-Network** $25 copay for each Medicare-covered service. *	**In-Network** $50 copay for each Medicare-covered service. * **Out-of-Network** 30% coinsurance for each Medicare-covered service. *
Diagnostic Services	**In-Network** 40% coinsurance * 1 diagnostic service(s) every year	**In-Network** 40% coinsurance * 1 diagnostic service(s) every year	**In-Network** 40% coinsurance * **Out-of-Network** Not covered 1 diagnostic service(s) every year

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Restorative Services	**In-Network** 40% coinsurance * 1 restorative service(s) every 12 to 84 months depending on type of service	**In-Network** 40% coinsurance * 1 restorative service(s) every 12 to 84 months depending on type of service	**In-Network** 40% coinsurance * **Out-of-Network** Not covered 1 restorative service(s) every 12 to 84 months depending on type of service
Endodontics/ Periodontics/ Extractions	**In-Network** 40% coinsurance * 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months depending on type of service 1 extraction(s) per tooth	**In-Network** 40% coinsurance * 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months depending on type of service 1 extraction(s) per tooth	**In-Network** 40% coinsurance * **Out-of-Network** Not covered 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months depending on type of service 1 extraction(s) per tooth

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Non-routine services	**In-Network** 40% coinsurance * 1 non-routine service(s) every date of service to 24 months depending on type of service	**In-Network** 40% coinsurance * 1 non-routine service(s) every date of service to 60 months depending on type of service	**In-Network** 40% coinsurance * **Out-of-Network** Not covered 1 non-routine service(s) every date of service to 60 months depending on type of service
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	**In-Network** 40% coinsurance * Prosthodontics - every 12 to 84 months depending on type of service. Oral/maxillofacial surgery - every 12 to 60 months or per lifetime depending on type of service.	**In-Network** 40% coinsurance * Prosthodontics - every 12 to 84 months depending on type of service Oral/maxillofacial surgery - every 12 to 60 months or per lifetime depending on type of service Other services - every 6 to 60 months depending on type of service	**In-Network** 40% coinsurance * **Out-of-Network** Not covered Prosthodontics - every 12 to 84 months depending on type of service Oral/maxillofacial surgery - every 12 to 60 months or per lifetime depending on type of service Other services - every 6 to 60 months depending on type of service

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Additional Dental Information	**What you should know:** This plan includes coverage of comprehensive services up to $2,000 per plan year.	**What you should know:** This plan includes coverage of comprehensive services up to $4,000 per plan year.	**What you should know:** This plan includes coverage of comprehensive services up to $4,000 per plan year.
Vision Services Eye Exam Medicare Covered	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) $45 copay (all other Medicare-covered eye exams) ▪ *	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) $25 copay (all other Medicare-covered eye exams) ▪ *	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) $50 copay (all other Medicare-covered eye exams) ▪ * **Out-of-Network** 30% coinsurance *
Routine eye exam (Refraction)	**In-Network** $0 copay ▪ * 1 exam every year	**In-Network** $0 copay ▪ * 1 exam every year	**In-Network** $0 copay ▪ * **Out-of-Network** Not covered 1 exam every year

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Glaucoma screening	**In-Network** $0 copay for each Medicare-covered service.	**In-Network** $0 copay for each Medicare-covered service.	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 30% coinsurance for each Medicare-covered service. *
Eyewear Medicare Covered	**In-Network** $0 copay ▪ *	**In-Network** $0 copay ▪ *	**In-Network** $0 copay ▪ * **Out-of-Network** 30% coinsurance *
Routine eyewear			
Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames	**In-Network** $0 copay ▪ *	**In-Network** $0 copay ▪ *	**In-Network** $0 copay ▪ * **Out-of-Network** <u>Not</u> covered
Eyewear allowance	Up to a $200 combined allowance towards contacts and glasses (lenses and/or frames) every year.	Up to a $300 combined allowance towards contacts and glasses (lenses and/or frames) every year.	Up to a $200 combined allowance towards contacts and glasses (lenses and/or frames) every year.

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Mental Health Services			
Inpatient visit	**In-Network** For each admission, you pay: • $2,106 copay per stay for days 1 through 90 *	**In-Network** For each admission, you pay: • $250 copay per day for days 1 through 7 • $0 copay per day for days 8 through 90 *	**In-Network** For each admission, you pay: • $575 copay per day for days 1 through 3 • $0 copay per day for days 4 through 90 * **Out-of-Network** Days 1-90: 30% coinsurance per admission. *
Outpatient individual therapy visit	**In-Network** $25 copay *	**In-Network** $25 copay *	**In-Network** $25 copay * **Out-of-Network** 30% coinsurance *
Outpatient group therapy visit	**In-Network** $25 copay *	**In-Network** $25 copay *	**In-Network** $25 copay * **Out-of-Network** 30% coinsurance *

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	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Skilled nursing facility (SNF)	**In-Network** For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 50 • $0 copay per day for days 51 through 100 *	**In-Network** For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 60 • $0 copay per day for days 61 through 100 *	**In-Network** For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $196 copay per day for days 21 through 60 • $0 copay per day for days 61 through 100 * **Out-of-Network** Days 1 - 100: 30% coinsurance per benefit period. *
Therapy and Rehabilitation Services Physical Therapy	**In-Network** $40 copay *	**In-Network** $25 copay *	**In-Network** $40 copay * **Out-of-Network** 30% coinsurance *

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Outpatient rehabilitation services provided by an occupational therapist	**In-Network** $40 copay *	**In-Network** $25 copay *	**In-Network** $40 copay * **Out-of-Network** 30% coinsurance *
Pulmonary rehabilitation services	**In-Network** $20 copay	**In-Network** $20 copay	**In-Network** $20 copay **Out-of-Network** 30% coinsurance *
Ambulance Ground Ambulance	**In-Network** $305 copay *	**In-Network** $235 copay *	**In-Network** $290 copay * **Out-of-Network** 30% coinsurance
Air Ambulance	**In-Network** $305 copay *	**In-Network** $235 copay *	**In-Network** $290 copay * **Out-of-Network** 30% coinsurance

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Transportation Services	**In-Network** Not covered	Up to 36 one-way trips every year to plan-approved health-related locations. **In-Network** $0 copay (per one-way trip) * **What you should know:** Mileage limitations may apply. Call Member Services 72 hours in advance to reserve a ride for your appointment.	Up to 12 one-way trips every year to plan-approved health-related locations. **In-Network** $0 copay (per one-way trip) * **Out-of-Network** Not covered **What you should know:** Mileage limitations may apply. Call Member Services 72 hours in advance to reserve a ride for your appointment.

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Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Medicare Part B Drugs Chemotherapy drugs	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 30% coinsurance *
Other Part B drugs	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 30% coinsurance *

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Prescription Drug Coverage	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Stage 1: Annual Prescription Deductible			
Deductible	This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.	$505 for Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Speciality Tier) Part D prescription drugs. For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately.	Not covered
Stage 2: Initial Coverage (after you pay your deductible, if applicable)			
You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.			
For plans with Part D coverage - Important Message About What You Pay for Vaccines and Insulin: Our plan covers most Part D vaccines at no cost to you, even if you have not paid your deductible (if your plan has a deductible). You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it is on, even if you have not paid your deductible (if your plan has a deductible).			
Retail cost-sharing (30-day/90-day supply)			

	Preferred	Standard	Preferred	Standard	Standard
Tier 1 Preferred Generic Drugs	$0 / $0 copay	$5 / $15 copay	$0 / $0 copay	$19 / $57 copay	Not covered
Tier 2 Generic Drugs	$5 / $15 copay	$15 / $45 copay	$20 / $60 copay	$20 / $60 copay	Not covered
Tier 3 Preferred Brand Drugs	$37 / $111 copay	$47 / $141 copay	$47 / $141 copay	$47 / $141 copay	Not covered

Prescription Drug Coverage	**Wellcare No Premium (HMO) H4847, Plan 001**		**Wellcare Assist (HMO) H4847, Plan 005**		**Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006**
	Preferred	**Standard**	**Preferred**	**Standard**	**Standard**
Tier 4 Non-Preferred Drugs	$80 / $240 copay	$90 / $270 copay	47% / 47% coinsurance	47% / 47% coinsurance	Not covered
Tier 5 Specialty Tier	33% coinsurance / Not Available	33% coinsurance / Not Available	25% coinsurance / Not Available	25% coinsurance / Not Available	Not covered
Tier 6 Select Care Drugs	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	Not covered

Prescription Drug Coverage	Wellcare No Premium (HMO) H4847, Plan 001		Wellcare Assist (HMO) H4847, Plan 005		Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)					
Mail-order cost-sharing (30-day/90-day supply)					
	Preferred	**Standard**	**Preferred**	**Standard**	**Standard**
Tier 1 Preferred Generic Drugs	$0 / $0 copay	$5 / $15 copay	$0 / $0 copay	$19 / $57 copay	Not covered
Tier 2 Generic Drugs	$5 / $0 copay	$15 / $45 copay	$20 / $0 copay	$20 / $60 copay	Not covered
Tier 3 Preferred Brand Drugs	$37 / $74 copay	$47 / $141 copay	$47 / $94 copay	$47 / $141 copay	Not covered
Tier 4 Non-Preferred Drugs	$80 / $160 copay	$90 / $270 copay	47% / 47% coinsurance	47% / 47% coinsurance	Not covered
Tier 5 Specialty Tier	33% coinsurance / Not Available	33% coinsurance / Not Available	25% coinsurance / Not Available	25% coinsurance / Not Available	Not covered
Tier 6 Select Care Drugs	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	Not covered

Prescription Drug Coverage	Wellcare No Premium (HMO) H4847, Plan 001		Wellcare Assist (HMO) H4847, Plan 005		Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
	Preferred	**Standard**	**Preferred**	**Standard**	**Standard**
Stage 3: Coverage Gap					
	After your total drug costs (including what our plan has paid and what you have paid) reach $4,660, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap. During this stage, for select drugs on Tier 6 you pay your copayment or coinsurance. Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.		After your total drug costs (including what our plan has paid and what you have paid) reach $4,660, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.		Not covered
Stage 4: Catastrophic Coverage					
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: • 5% coinsurance, or • $4.15 copay for generic (including brand drugs treated as generic) and $10.35 copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: • 5% coinsurance, or • $4.15 copay for generic (including brand drugs treated as generic) and $10.35 copay for all other drugs.		Not covered

Generic drugs may be covered on tiers other than Tier 1 and Tier 2. Please check this plan's Formulary to validate the specific tier on which your drugs are covered.

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (30-day supply) or long term (90-day supply).

Excluded Drugs:

Wellcare No Premium (HMO) include(s) enhanced drug coverage of certain excluded drugs. Generic only Sildenafil and Vardenafil on Tier 1 have a quantity limit of six pills every 30 days.

Because these drugs are excluded from Part D coverage under Medicare, they are not covered by Extra Help. Also, the amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage.

Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.

Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Chiropractic Services Medicare-covered	**In-Network** $20 copay *	**In-Network** $20 copay *	**In-Network** $20 copay * **Out-of-Network** 30% coinsurance *
Acupuncture Medicare-covered	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. $45 copay for Medicare-covered Acupuncture received in a Specialist office. $20 copay for Medicare-covered Acupuncture received in a Chiropractor office. *	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. $25 copay for Medicare-covered Acupuncture received in a Specialist office. $20 copay for Medicare-covered Acupuncture received in a Chiropractor office. *	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. $50 copay for Medicare-covered Acupuncture received in a Specialist office. $20 copay for Medicare-covered Acupuncture received in a Chiropractor office. * **Out-of-Network** 30% coinsurance *

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Podiatry Services (Foot Care) Medicare Covered	**In-Network** $45 copay *	**In-Network** $25 copay *	**In-Network** $50 copay * **Out-of-Network** 30% coinsurance *
Virtual Visits	Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors via Teladoc to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more. A virtual visit (also known as a telehealth consult) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device. For more information, or to schedule an appointment, call Teladoc at 1-800-835-2362 (TTY: 711) 24 hours a day, 7 days a week.		
Home health agency care	**In-Network** $0 copay *	**In-Network** $0 copay *	**In-Network** $0 copay * **Out-of-Network** 30% coinsurance *

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	**Wellcare Assist (HMO) H4847, Plan 005**	**Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006**
Meals			
Post-Acute Meals	$0 copay ▪ **What you should know:** You pay nothing for meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days with a maximum of 42 meals per occurrence for an unlimited number of occurrences per year.	$0 copay ▪ **What you should know:** You pay nothing for meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days with a maximum of 42 meals per occurrence for an unlimited number of occurrences per year.	$0 copay ▪ **What you should know:** You pay nothing for meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days with a maximum of 42 meals per occurrence for an unlimited number of occurrences per year.

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	**Wellcare Assist (HMO) H4847, Plan 005**	**Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006**
Chronic Meals	$0 copay ▪ **What you should know:** You pay nothing for home delivered meals as part of a supervised program designed to transition members with specific chronic conditions to lifestyle modifications. Members receive 3 meals per day for up to 28 days, for a maximum of 84 meals per month. The benefit can be received for up to 3 months.	$0 copay ▪ **What you should know:** You pay nothing for home delivered meals as part of a supervised program designed to transition members with specific chronic conditions to lifestyle modifications. Members receive 3 meals per day for up to 28 days, for a maximum of 84 meals per month. The benefit can be received for up to 3 months.	$0 copay ▪ **What you should know:** You pay nothing for home delivered meals as part of a supervised program designed to transition members with specific chronic conditions to lifestyle modifications. Members receive 3 meals per day for up to 28 days, for a maximum of 84 meals per month. The benefit can be received for up to 3 months.
Medical Equipment/Supplies Durable Medical Equipment (DME)	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 30% coinsurance *

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Prosthetics	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 30% coinsurance *
Diabetic supplies	**In-Network** $0 copay * Limitations may apply	**In-Network** $0 copay * Limitations may apply	**In-Network** $0 copay * **Out-of-Network** 30% coinsurance * Limitations may apply
Diabetic therapeutic shoes or inserts	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 30% coinsurance *
Opioid treatment program services	**In-Network** $45 copay *	**In-Network** $25 copay *	**In-Network** $50 copay * **Out-of-Network** 30% coinsurance *

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Over-the-Counter (OTC) Items	$0 copay Maximum benefit is $73 every three months to spend on plan-approved OTC items. Limitations may apply. At the end of each benefit period, any unused benefit dollars will expire. **What you should know:** You can purchase eligible OTC items from participating CVS retail locations with your plan's Member ID Card or from the catalog by phone or online for home delivery. - To place an order over the phone call: 1-866-819-2516, (TTY 711) - Order via the catalog online at www.cvs.com/otchs/wellcare	$0 copay Maximum benefit is $125 every three months to spend on plan-approved OTC items. Limitations may apply. At the end of each benefit period, any unused benefit dollars will expire. **What you should know:** You can purchase eligible OTC items from participating CVS retail locations with your plan's Member ID Card or from the catalog by phone or online for home delivery. - To place an order over the phone call: 1-866-819-2516, (TTY 711) - Order via the catalog online at www.cvs.com/otchs/wellcare	$0 copay Maximum benefit is $50 every three months to spend on plan-approved OTC items. Limitations may apply. At the end of each benefit period, any unused benefit dollars will expire. **What you should know:** You can purchase eligible OTC items from participating CVS retail locations with your plan's Member ID Card or from the catalog by phone or online for home delivery. - To place an order over the phone call: 1-866-819-2516, (TTY 711) - Order via the catalog online at www.cvs.com/otchs/wellcare

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Wellness Programs	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.
Fitness	$0 copay Coverage includes: Activity Tracker and Physical Fitness	$0 copay Coverage includes: Activity Tracker and Physical Fitness	$0 copay Coverage includes: Activity Tracker and Physical Fitness

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
	What you should know: This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A fitness tracker may be selected as part of a home fitness kit.	**What you should know:** This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A fitness tracker may be selected as part of a home fitness kit.	**What you should know:** This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A fitness tracker may be selected as part of a home fitness kit.
Additional sessions of smoking and tobacco cessation counseling	**In-Network** $0 copay Limited to 5 visit(s) every year	**In-Network** $0 copay Limited to 5 visit(s) every year	**In-Network** $0 copay **Out-of-Network** Not covered Limited to 5 visit(s) every year

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Additional Routine Annual Physical	**In-Network** $0 copay **What you should know:** The exam includes a detailed medical/family history, performance of a detailed head-to-toe assessment with a hands-on examination of all the body systems, recommendations for preventive screenings/care, and counseling about healthy behaviors, and is beyond the Annual Wellness Visit services.	**In-Network** $0 copay **What you should know:** The exam includes a detailed medical/family history, performance of a detailed head-to-toe assessment with a hands-on examination of all the body systems, recommendations for preventive screenings/care, and counseling about healthy behaviors, and is beyond the Annual Wellness Visit services.	**In-Network** $0 copay **Out-of-Network** Not covered **What you should know:** The exam includes a detailed medical/family history, performance of a detailed head-to-toe assessment with a hands-on examination of all the body systems, recommendations for preventive screenings/care, and counseling about healthy behaviors, and is beyond the Annual Wellness Visit services.
24-Hour Nurse Advice Line	$0 copay	$0 copay	$0 copay
Personal emergency medical response device (PERS)	Not covered	Not covered	$0 copay

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Additional Benefits

	Wellcare No Premium (HMO) H4847, Plan 001	Wellcare Assist (HMO) H4847, Plan 005	Wellcare Patriot Giveback (HMO-POS) H4847, Plan 006
Flex Card	Not covered	$200 yearly benefit **What you should know:** The flex card benefit is a debit card that may be used to cover out of pocket dental, vision or hearing costs.	Not covered
In-home support services	Not covered	Not covered	$0 copay for each in-home support services visit. Up to 24 visits every year. **What you should know:** You can receive Chore Services if you meet certain clinical criteria. Services must be recommended or requested by a licensed plan clinician or a licensed plan provider. Services are provided in two hour increments.

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Multi-Language Insert

Multi-Language Interpreter Services

Spanish: Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para obtener un intérprete, simplemente llámenos a los números del plan que figuran en las siguientes páginas. Alguien que hable español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我们有免费的口译服务来回答您就我们的健康或药物计划提出的任何问题。如需口译员，只需拨打以下页面上的计划号码致电联系我们。会说中文普通话的人员可以协助您。此为免费服务。

Chinese Cantonese: 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打以下頁面上的計劃號碼致電聯絡我們。會說粵語的人員可以協助您。此為免費服務。

Tagalog: Meron kaming libreng serbisyo ng interpreter para sagutin anumang tanong na meron ka tungkol sa aming plano ng kalusugan o gamot. Para makakuha ng interpreter, tawagan lang kami sa mga numero ng plano na nasa sumusunod na mga pahina. Matutulungan ka ng sinumang nagsasalita ng Tagalog. Libreng serbisyo ito.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser au sujet de notre régime de soins médicaux ou de notre régime d'assurance-médicaments. Pour bénéficier des services d'un interprète, il suffit de nous appeler aux numéros de régime indiqués dans les pages suivantes. Quelqu'un qui parle français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi cung cấp dịch vụ phiên dịch viên miễn phí để trả lời bất kỳ câu hỏi nào quý vị có về chương trình y tế hoặc thuốc của chúng tôi. Để nhận được dịch vụ phiên dịch, chỉ cần gọi cho chúng tôi theo số điện thoại của chương trình trong các trang sau. Người nào đó nói tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetscherdienst, um alle Ihre Fragen zu unserem Gesundheits- oder Medikamentenplan zu beantworten. Um einen Dolmetscher zu finden, rufen Sie uns einfach unter den auf den folgenden Seiten angegebenen Plan-Nummern an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dieser Service ist für Sie kostenlos.

Korean: 저희의 건강 또는 약품 플랜에 대한 질문에 답해 드릴 수 있는 무료 통역 서비스를 제공합니다. 통역사에게 연결하려면 다음 페이지에 있는 플랜 번호로 전화하시기 바랍니다. 한국어를 하는 분이 도와드릴 수 있습니다. 이 통화는 무료 서비스입니다.

Russian: Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы, которые могут возникнуть у вас о нашем плане медицинского страхования или страхового покрытия лекарственных препаратов. Чтобы получить устного переводчика, просто позвоните нам по номерам планов, указанным на следующих страницах. Вам поможет тот, кто говорит по-русски. Эта услуга предоставляется бесплатно.

Arabic: نوفر خدمات مترجم فوري للإجابة عن أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. للاستعانة بمترجم، ما عليك سوى الاتصال بنا على أرقام الخطة في الصفحات التالية. شخص يتحدث العربية بمكنه مساعدتك. هذه الخدمة تقدم مجانًا.

Hindi: हमारे स्वास्थ्य या दवा योजना के बारे में आपके होने वाले किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं। दुभाषिया प्राप्त करने के लिए, हमें निम्नलिखित पृष्ठों पर दिए गए प्लान नंबरों पर कॉल करें। कोई हिंदी भाषी व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Italian: Disponiamo di servizi di interpretariato gratuiti per rispondere ad eventuali domande in merito al nostro piano sanitario o farmaceutico. Per ottenere un interprete, chiami i recapiti del piano disponibili nelle pagine successive. Qualcuno che parla italiano Le sarà d'aiuto. Si tratta di un servizio gratuito.

Portugués: Temos serviços de intérprete gratuitos para responder quaisquer perguntas que você possa ter sobre nossos planos de saúde ou de medicamentos. Para solicitar um intérprete, ligue para nós através dos números do plano nas páginas a seguir. Um funcionário que fala português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan nimewo plan yo ki sou paj annapre yo. Yon moun ki pale Kreyòl Franse kapab ede ou. Se yon sèvis gratis li ye.

Polish: Oferujemy bezpłatne usługi tłumaczeniowe w przypadku pytań dotyczących naszego planu zdrowotnego i lekowego. Aby skorzystać z tłumacza, prosimy zadzwonić do nas pod numery podane na kolejnych stronach. Pomocą posłużą osoby mówiące po polsku. Usługa jest bezpłatna.

Japanese: 当社の医療プランまたは処方薬プランについての質問にお答えする無料の通訳サービスをご利用いただけます。通訳サービスをご利用になるには、以降のページにおけるプランの番号までお電話ください。日本語を話すスタッフが対応いたします。これは無料のサービスです。

Hawaiian: Aia iā mākou he mau lawelawe māhele ʻōlelo manuahi e pane i nā ʻano nīnau āu no ka mākou papahana mālama olakino a hoʻolako lāʻau. No ka ʻimi i mea māhele ʻōlelo, e kelepona wale mai iā mākou ma nā helu kelepona e waiho nei ma kēia mau ʻaoʻao e koe nei. Na kekahi māhele ʻōlelo Hawaiʻi e kōkua iā ʻoe. He lawelawe manuahi kēia.

Ilocano: Addaankami kadagiti libre a serbisio ti panagipatarus tapno masungbatan dagiti aniaman a saludsodmo maipapan iti salun-at wenno plano iti agas. Tapno makaala iti tagaipatarus, tawagannakami laeng kadagiti numero ti plano kadagiti sumaganad a panid. Matulongannaka ti maysa a tao nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

Samoan: E iai a matou auaunaga faʼaliliu upu fua e tali ai soʻo se fesili e te ono iai e uiga i la matou fuafuaga faʼalesoifua maloloina poʻo vailaʼau. Mo le mauaina o se faʼaliliu upu, naʻo le valaʼau mai i numera o fuafuaga o loʻo i itulau nei. E mafai e se tasi e tautala i le gagana Samoa ona fesoasoani ia te oe. Ose auaunaga e leai se totogi.

We're Just a **Phone Call Away**

CALIFORNIA

- HMO, HMO D-SNP
- **1-866-999-3945**

HAWAII

- HMO, PPO, HMO D-SNP
- **1-877-457-7621**

ILLINOIS*

- HMO, HMO-POS, HMO C-SNP, PPO
- **1-833-444-9088**

GEORGIA, ILLINOIS**, INDIANA, MICHIGAN, OHIO AND SOUTH CAROLINA

- HMO, HMO C-SNP, HMO D-SNP, HMO-POS, HMO-POS C-SNP, HMO-POS D-SNP, PPO, PPO D-SNP
- **1-866-892-8340**

ALL OTHER STATES

- HMO, HMO C-SNP, HMO-POS, HMO-POS C-SNP, PFFS, PPO
- **1-833-444-9088**
- HMO D-SNP, HMO-POS D-SNP, PPO D-SNP
- **1-833-444-9089**

TTY FOR ALL OF THE ABOVE: 711

HOURS OF OPERATION

October 1 to March 31: Monday–Sunday, 8 a.m. to 8 p.m.

April 1 to September 30: Monday–Friday, 8 a.m. to 8 p.m.

Or visit www.wellcare.com/medicare or www.wellcare.com/ohana

**Wellcare Assist (HMO), Wellcare Assist Compass (HMO), Wellcare Giveback (HMO), Wellcare Giveback Dividend (HMO), Wellcare Giveback Open (PPO), Wellcare Low Premium (HMO-POS), Wellcare No Premium (HMO), Wellcare No Premium (HMO-POS), Wellcare No Premium Open (PPO), Wellcare No Premium Preferred (HMO), Wellcare No Premium Value (HMO), Wellcare Patriot Giveback (HMO-POS), Wellcare Patriot No Premium (HMO-POS)*

***Wellcare Assist (HMO), Wellcare No Premium Essential (HMO), Wellcare No Premium Exclusive (HMO)*

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Services representative at 1-844-917-0175 (TTY: 711). Hours are Monday - Sunday, 8 am - 8 pm (all time zones).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.wellcare.com/medicare or call 1-844-917-0175 (TTY: 711) to view a copy of the EOC. Hours are Monday - Sunday, 8 am - 8 pm (all time zones).
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ **For HMO, CSNP and DSNP plans:** Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **For PPO, PFFS and POS plans:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Contact Us

For more information, please contact us:

By phone

Toll-free at 1-844-917-0175 (TTY 711). Your call may be answered by a licensed agent.

Hours of Operation

Monday - Sunday, 8 am - 8 pm (all time zones)

Online www.wellcare.com/medicare

We're with our members every step of the way.

Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.