2023
Summary of Benefits

California

Wellcare Dual Align 001 (HMO D-SNP)

H5087 | 001

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Introduction

This document is a brief summary of the benefits and services covered by Wellcare Dual Align 001 (HMO D-SNP), a Medicare Medi-Cal Plan. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of Wellcare. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook.*

Table of Contents

A. Disclaimers

This is a summary of health services covered by Wellcare, a Medicare Medi-Cal Plan for 2023. This is only a summary. Please read the *Member Handbook* for the full list of benefits. You can find the *Member Handbook* on our website at www.wellcare.com/en/California. To request a copy, please call 1-866-999-3945 (TTY: 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

- 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 Member Services number or see your *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.
- Medicare approved Wellcare to provide these benefits as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.
- Benefits mentioned may be a part of Special Supplemental Benefits for the Chronically Ill. Not all members will qualify.
- For more information about **Medicare**, you can read the *Medicare & You* handbook. It has a summary of Medicare benefits, rights, and protections and answers to the most frequently asked questions about Medicare. You can get it at the Medicare website (www.medicare.gov) or 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. For more information about **Medi-Cal**, you can check the California Department of Healthcare Services (DHCS) website (www.dhcs.ca.gov) or contact the Medi-Cal Office of the Ombudsman 1-888-452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m. You can also call the special Ombudsman for people who have both Medicare and Medi-Cal, at 1-855-501-3077, Monday through Friday, between 9:00 a.m. and 5:00 p.m.
- You can get this document for free in other formats, such as large print, braille, or audio. Call 1-866-999-3945 (TTY: 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. The call is free.

❖ Wellcare wants to make sure you understand your health plan information. We can send materials to you in another language or alternate format if you ask for it this way. This is called a “standing request.” We will document your choice.

Please call us if:

- You want to get your materials in Arabic, Armenian, Cambodian (Khmer), Chinese (traditional characters), Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese or in an alternate format. You can ask for one of these languages in an alternate format.
- You want to change the language or format that we send you materials.

If you need help understanding your plan materials, please contact Wellcare Member Services at 1-866-999-3945 (TTY: 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

B. Frequently asked questions (FAQ)

The following table lists frequently asked questions.

Frequently Asked Questions	Answers
What is a Medicare Medi-Cal Plan?	A Medicare Medi-Cal Plan is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. It is for people age 65 and older. A Medicare Medi-Cal Plan is an organization made up of doctors, hospitals, pharmacies, providers of Long-term Services and Supports (LTSS), and other providers. It also has care coordinators to help you manage all your providers and services and supports. They all work together to provide the care you need.

Frequently Asked Questions	Answers
Will I get the same Medicare and Medi-Cal benefits in Wellcare that I get now?	You will get most of your covered Medicare and Medi-Cal benefits directly from Wellcare. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change based on your needs, and your doctor and care team's assessment. You may also get other benefits outside of your health plan the same way you do now, directly from a State or county agency like In-Home Support Services (IHSS), specialty mental health and substance use disorder services, or regional center services. When you enroll in Wellcare, you and your care team will work together to develop a care plan to address your health and support needs, reflecting your personal preferences and goals. If you are taking any Medicare Part D prescription drugs that Wellcare does not normally cover, you can get a temporary supply and we will help you to transition to another drug or get an exception for Wellcare to cover your drug if medically necessary. For more information, call Member Services at the numbers listed at the bottom of this page.
Can I go to the same doctors I use now? (continued on the next page)	Often that is the case. If your providers (including doctors, hospitals, therapists, pharmacies, and other health care providers) work with Wellcare and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." Network providers participate in our plan. That means they accept members of our plan and provide services our plan covers. **You must use the providers in Wellcare's network.** If you use providers or pharmacies that are not in our network, the plan may not pay for these services or drugs. • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of Wellcare's plan. Wellcare covers out-of-network emergency care. Worldwide emergency services are subject to a $50,000 maximum plan

Frequently Asked Questions	Answers
Can I go to the same doctors I use now? (continued from the previous page)	coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. • If you are currently under treatment with a provider that is out of Wellcare's network, or have an established relationship with a provider that is out of Wellcare's network, call Member Services to check about staying connected. • If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, if they are not in our network. We call this continuity of care. If they are not in our network, you can keep your current providers and service authorizations at the time you enroll for up to 12 month if certain conditions are met. Refer to the *Member Handbook*, Chapter 1, Section F to learn more. To find out if your doctors are in the plan's network, call Member Services at the numbers listed at the bottom of this page or read Wellcare's *Provider and Pharmacy Directory* on the plan's website at www.wellcare.com/California/Find-a-Provider#/Search. If Wellcare is new for you, we will work with you to develop a care plan to address your needs.
What is a Wellcare care coordinator?	A Wellcare care coordinator is one main person for you to contact. This person helps to manage all your providers and services and make sure you get what you need.
What are Long-term Services and Supports (LTSS)?	Long-term Services and Supports are help for people who need assistance to do everyday tasks like bathing, toileting, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. In some cases, a county or other agency may administer these services, and your care coordinator or care team will work with that agency.

Frequently Asked Questions	Answers
What is a Multipurpose Senior Services Program (MSSP)?	A MSSP provides on-going care coordination with health care providers beyond what your health plan already provides, and can connect you to other needed community services and resources. This program helps you get services that help you live independently in your home.
What happens if I need a service but no one in Wellcare's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, Wellcare will pay for the cost of an out-of-network provider.
Where is Wellcare available?	The service area for this plan includes: Los Angeles County, CA. You must live in this area to join the plan.
What is prior authorization?	Prior authorization means an approval from Wellcare to seek services outside of our network or to get services not routinely covered by our network **before** you get the services. Wellcare may not cover the service, procedure, item, or drug if you don't get prior authorization. **If you need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first**. Wellcare can provide you or your provider with a list of services or procedures that require you to get prior authorization from Wellcare before the service is provided. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services at the numbers listed at the bottom of this page for help.

Frequently Asked Questions	Answers
What is a referral?	A referral means that your primary care provider (PCP) must give you approval to go to someone that is not your PCP. A referral is different than a prior authorization. If you don't get a referral from your PCP, Wellcare may not cover the services. Wellcare can provide you with a list of services that require you to get a referral from your PCP before the service is provided. Refer to the *Member Handbook* Chapter 3, Section B to learn more about when you will need to get a referral from your PCP.
Do I pay a monthly amount (also called a premium) under Wellcare?	No. Because you have Medi-Cal, you will not pay any monthly premiums, including your Medicare Part B premium, for your health coverage.
Do I pay a deductible as a member of Wellcare?	No. You do not pay deductibles in Wellcare.
What is the maximum out-of-pocket amount that I will pay for medical services as a member of Wellcare?	There is no cost sharing for medical services in Wellcare, so your annual out-of-pocket costs will be $0.

C. List of covered services

The following table is a quick overview of what services you may need, your costs, and rules about the benefits.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Hospital stay	$0	There are no limits to the number of medically necessary covered days by the Plan for each hospital stay. Except in an emergency, your doctor must tell the Plan that you are going to be admitted to the hospital. You must go to network doctors, specialists, and hospitals. Referral and prior authorization may be required.
	Doctor or surgeon care	$0	Doctor and surgeon care is provided as part of your hospital stay. Referral and prior authorization may be required.
	Outpatient hospital services, including observation	$0	Referral and prior authorization may be required.
	Ambulatory surgical center (ASC) services	$0	Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor (continued on the next page)	Visits to treat an injury or illness	$0	If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. For routine visits, referral and prior authorization rules may apply. You must go to network doctors, specialists, and hospitals.
	Specialist care	$0	You must go to network doctors, specialists, and hospitals. Referral and prior authorization may be required.
	Wellness visits, such as a physical	$0	Annual wellness visit every 12 months. • Bone Mass Measurement (for people with Medicare who are at risk) • Colorectal Screening Exams (for people with Medicare age 50 and older) • Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine) • Mammograms (Annual Screening) (for women with Medicare age 40 and older) • Pap Smears and Pelvic Exams (for women with Medicare) • And other Wellness Benefits

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor (continued from the previous page)	Care to keep you from getting sick, such as flu shots and screenings to check for cancer	$0	You must see one of our network providers.
	"Welcome to Medicare" (preventative visit one time only)	$0	During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visit or an annual wellness visit. After your first 12 months, you can get one annual wellness visit every 12 months.
You need emergency care (continued on the next page)	Emergency room services	$0	Wellcare covers out-of-network emergency care. You may get covered emergency care whenever you need it. Emergency room care is for a medical issue that is a threat to your life, or that could cause serious harm if not treated right away. $95 copay for Worldwide emergency services. Worldwide emergency 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. No prior authorization or referral necessary for emergency room services.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care (continued from the previous page)	Urgent care	$0	If you require urgent care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend). $95 copay for Worldwide urgently needed services. Worldwide urgently needed services are subject to a $50,000 maximum plan coverage. No prior authorization or referral necessary for urgent care.
You need medical tests (continued on the next page)	Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs)	$0	We pay for the following services and other medically necessary services not listed here: • X-rays • Splints, casts, and other devices used for fractures and dislocations • Blood, including storage and administration Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests (continued from the previous page)	Lab tests and diagnostic procedures, such as blood work	$0	COVID-19 testing and specified testing-related services at any location are $0. Referral and prior authorization may be required.
You need hearing/auditory services	Hearing screenings	$0	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. Our plan also covers: • 1 routine hearing exam every year Referral and prior authorization may be required.
	Hearing aids	$0	Our plan covers the following: • 1 hearing aid fitting and evaluation every year. • Up to a $1,000 allowance per ear every year for hearing aids. Limited to 2 hearing aids every year. Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care	Dental check-ups and preventive care	$0	Dental benefits are available in the Medi-Cal Dental Program. For more information you can visit the website at dental.dhcs.ca.gov/.
	Restorative and emergency dental care	$0	Dental benefits are available in the Medi-Cal Dental Program. For more information you can visit the website at dental.dhcs.ca.gov/. In addition to Medi-Cal Dental program, the plan offers: • Crowns – noble metals – once every 5 calendar years • Prosthodontics (dentures) – every 2 calendar years per arch • Bridges – every 5 calendar years per tooth Prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care	Eye exams	$0	1 routine eye exam every year. Referral and prior authorization may be required.
	Glasses or contact lenses	$0	Up to a $400 combined allowance towards contacts and glasses (frames and/or lenses) every year. Referral and prior authorization are required.
	Other vision care	$0	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need mental health services (continued on the next page)	Mental health services	$0	For dual-eligible members, Medi-Cal pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. • Outpatient Mental Health services • Outpatient Specialty Mental Health Services • Inpatient Specialty Mental Health services • Outpatient Substance Use Disorder services • Residential Treatment services • Voluntary Inpatient Detoxification Refer to Section D below regarding specialty mental health services covered by Medicare, Medi-Cal, or a State or county agency. Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need mental health services (continued from the previous page)	Inpatient and outpatient care and community-based services for people who need mental health services	$0	Through your Medi-Cal Fee-for-Service (FFS) benefits you get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. Plan covers 60 lifetime reserve days. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Prior authorization rules may apply. **Institution for Mental Disease Services for Individuals 65 or Older** Referral and prior authorization may be required. Contact the plan for details. Refer to Section D below regarding specialty mental health services covered by Medicare, Medi-Cal, or a State or county agency.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need substance use disorder services	Substance use disorder services	$0	Through your Medi-Cal Fee-for-Service (FFS) benefits you receive the following services, and maybe other services not listed here: • Alcohol misuse screening and counseling • Treatment of drug abuse • Group or individual counseling by a qualified clinician **Inpatient Hospital Care** Includes Substance Abuse and Rehabilitation Services. No limit to the number of days covered by the plan each hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Referral and prior authorization may be required. **Outpatient Substance Abuse Care** Individual substance abuse outpatient treatment visit. Group substance abuse outpatient treatment visit. Referral and prior authorization may be required. Refer to Section D below on how to access county substance use disorder services.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Skilled nursing care	$0	Referral and prior authorization may be required.
	Nursing home care	$0	Prior authorization may be required.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Referral and prior authorization may be required.
You need help getting to health services	Non-Emergency ambulance services	$0	Prior authorization may be required.
	Emergency transportation	$0	None.
	Transportation to medical appointments and services	$0	Unlimited one-way trips every year to plan-approved health-related locations. Call Member Services at least 3 days before or as soon as possible before your appointment to schedule your ride. Prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued on the next page)	Medicare Part B prescription drugs	$0	Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued from the previous page)	Generic drugs (no brand name)	$0	There may be limitations on the types of drugs covered. Please refer to Wellcare's *List of Covered Drugs* (Drug List) for more information. Some prescription drugs may require prior authorization or may require that you try a different drug first. Quantity limits may apply. An extended-day supply of some drugs is available through mail order and certain retail pharmacies at the same copay as a one-month supply. For more information, please refer to our *List of Covered Drugs* to view those drugs available for an extended-day supply.
	Brand name drugs	$0	There may be limitations on the types of drugs covered. Please refer to Wellcare's *List of Covered Drugs* (Drug List) for more information. Some prescription drugs may require prior authorization or may require that you try a different drug first. Quantity limits may apply. An extended-day supply of some drugs is available through mail order and certain retail pharmacies at the same copay as a one-month supply. For more information, please refer to our *List of Covered Drugs* to view those drugs available for an extended-day supply.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting better or have special health needs	Rehabilitation services	$0	Referral may be required.
	Medical equipment for home care	$0	Prior authorization may be required.
	Dialysis services	$0	Prior authorization may be required.
You need foot care (continued on the next page)	Podiatry services	$0	We pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes Additional routine foot care limited to 12 visits per year that includes cutting or removal of corns and calluses and trimming, cutting, or clipping of nails. Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need foot care (continued from the previous page)	Orthotic services	$0	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist, or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist, or the licensed practitioner, respectively. Prior Authorization may be required.
You need durable medical equipment (DME) **Note:** This is not a complete list of covered DME. For a complete list, contact Member Services or refer to Chapter 4 of the *Member Handbook*.	Wheelchairs, crutches, and walkers	$0	Prior authorization may be required.
	Nebulizers	$0	Prior authorization may be required.
	Oxygen equipment and supplies	$0	Prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued on the next page)	Home health services	$0	Referral and prior authorization may be required.
	Home services, such as cleaning or housekeeping, or home modifications such as grab bars	$0	If you meet certain clinical criteria, additional in-home services are available through Medi-Cal's In-Home Support Services (IHSS) Program through the Department of Social Services (DSS). Services must be recommended or requested by a licensed plan clinician or a licensed plan provider. You may participate in care management or be assessed by a care manager. Services will be provided in 4-hour increments, with a maximum of 12 visits per year. Call Member Services to find out more and be connected with your county social worker.
	Adult day health, Community Based Adult Services (CBAS), or other support services	$0	CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We pay for CBAS if you meet the eligibility criteria. Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued from the previous page)	Day habilitation services	$0	Prior authorization may be required.
	Services to help you live on your own (home health care services or personal care attendant services)	$0	Community Supports are medically appropriate and cost-effective alternative services or settings. These services are optional for members. If you qualify, these services may help you live more independently. They do not replace benefits that you already get under Medi-Cal. Examples of Community Supports that we offer include medically-supportive food and meals or medically-tailored meals, help for you or your caregiver, or shower grab bars and ramps.
Additional services (continued on the next page)	Chiropractic services	$0	Our plan covers an additional 24 routine chiropractic visits every year. Referral and prior authorization may be required.
	Acupuncture	$0	Our plan covers an additional 24 routine acupuncture visits every year. Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued from the previous page) (continued on the next page)	Diabetes supplies and services	$0	Diabetic glucometer and supplies are limited to OneTouch when obtained at a Pharmacy. Other brands and continuous glucose monitoring systems are not covered unless pre-authorized. Quantity limits may apply. Prior authorization may be required.
	Healthy Foods Card	$0	You receive an allowance of $50 every month to spend on eligible grocery products at participating retailers. Any unused amount will not carry over into the next month. Referral and prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued from the previous page) (continued on the next page)	Meals	$0	Post-Acute Meals 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, for a maximum of 42 meals. Chronic Meals 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 per month, for a maximum of 84 meals. The benefit can be received for up to 3 months. Referral may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued from the previous page) (continued on the next page)	Over-the-counter (OTC) Items	$0	Maximum benefit is $260 every three months to spend on plan-approved over-the-counter items. Limitations may apply. At the end of each benefit period, any unused benefit dollars will expire. Note: 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. The Medi-Cal Rx program also covers some OTC items. Ask your Provider or Pharmacist for assistance.
	Prosthetic services	$0	Our plan pays for some prosthetic devices including pacemakers, prosthetic shoes and breast prostheses. We also pay for the repair or replacement of prosthetic devices. Prior authorization may be required.
	Radiation therapy	$0	Radiation (radium and isotope) therapy, including technician materials and supplies. Prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued from the previous page) (continued on the next page)	Services to help manage your disease	$0	We will pay for training to help you manage your diabetes, in some cases. To find out more, contact Member Services. Referral may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued from the previous page)	Wellness Programs	$0	We offer many programs that focus on certain health conditions. These include: • Activity Tracker; • Health Education classes; • Nutrition Education classes; • Smoking and Tobacco Use Cessation; • Nursing Hotline; and • Fitness benefit The benefit on this plan provides a membership to a flexible fitness benefit with monthly credits to use on a variety of larger gyms or local fitness studios. Members will have 32 credits each month to utilize. Credits will be sufficient to cover a monthly gym membership and/or fitness studio classes, or at-home fitness boxes and fitness videos. • Personal emergency medical response device (PERS): Coverage for one personal emergency medical response device per lifetime and the monthly fee. A personal emergency medical response device provides peace of mind and 24/7 response to your emergent and non-emergent needs. For a detailed list of wellness program benefits offered, please refer to the *Member Handbook*.

The above summary of benefits is provided for informational purposes only and is not a complete list of benefits. For a complete list and more information about your benefits, you can read the Wellcare *Member Handbook*. If you don't have a *Member Handbook*, call Wellcare Member Services at the numbers listed at the bottom of this page to get one. If you have questions, you can also call Member Services or visit www.wellcare.com/en/California.

D. Benefits covered outside of Wellcare

There are some services that you can get that are not covered by Wellcare but are covered by Medicare, Medi-Cal, or a State or county agency. This is not a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about these services.

Other services covered by Medicare, Medi-Cal, or a State Agency	Your costs
Medi-Cal Dental Program	$0
Assisted Living Waiver (ALW)	$0
Multi-Purpose Senior Services Program (MSSP)	$0
Regional Center Services	$0
County Specialty Mental Health and Substance Use Disorder (SUD) Services or Providers	$0
Home and Community-Based Waiver Services (HCBS) or Providers	$0
In-Home Support Services (IHSS) or Providers	$0
Medi-Cal Rx: Medi-Cal Covered Rx Services or Providers	$0
Denti-Cal Plans: Medi-Cal Dental Services or Providers	$0
Certain hospice care services covered outside of Wellcare	$0
Psychosocial rehabilitation	$0
Targeted case management	$0
Rest home room and board	$0

E. Services that Wellcare, Medicare, and Medi-Cal do not cover

This is not a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other excluded services.

Services Wellcare, Medicare, and Medi-Cal do not cover	
Services considered not "reasonable and medically necessary," according to Medicare and Medi-Cal standards, unless we list these as covered services.	Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.	A private room in a hospital, except when medically necessary.
Private duty nurses.	Full-time nursing care in your home.

F. Your rights as a member of the plan

As a member of Wellcare, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
  - Get covered services without concern about medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, or public assistance
  - Get information in other languages and formats (for example, large print, braille, or audio) free of charge

- Be free from any form of physical restraint or seclusion

- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a language and format you can understand. This includes the right to get information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers

- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they are covered
  - Refuse treatment, even if your health care provider advises against it
  - Stop taking medicine, even if your health care provider advises against it
  - Ask for a second opinion. Wellcare will pay for the cost of your second opinion visit
  - Make your health care wishes known in an advance directive

- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your health care providers and your health plan

- **You have the right to seek emergency and urgent care when you need it.** This means you have the right to:
  - Get emergency services without prior authorization in an emergency
  - Use an out-of-network urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private
- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - File a complaint or grievance against us or our providers
  - File a complaint with the California Department of Managed Health Care (DMHC) through a toll-free phone number (1-888-466-2219), or a TDD line (1-877-688-9891) for the hearing and speech impaired. The DMHC website (www.dmhc.ca.gov) has complaint forms, Independent Medical Review (IMR) application forms, and instructions available online.
  - Ask DMHC for an IMR of Medi-Cal services or items that are medical in nature
  - Appeal certain decisions made by DMHC or our providers
  - Ask for a State Hearing
  - Get a detailed reason for why services were denied

For more information about your rights, you can read the *Member Handbook*. If you have questions, you can call Wellcare Member Services at the numbers listed at the bottom of this page.

You can also call the special Ombudsman for people who have Medicare and Medi-Cal at 1-855-501-3077, Monday through Friday, between 9:00 a.m. and 5:00 p.m., or the Medi-Cal Office of the Ombudsman 1-888-452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m.

G. How to file a complaint or appeal a denied service

If you have a complaint or think Wellcare should cover something we denied, call Member Services at the numbers listed at the bottom of this page. You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the *Member Handbook*. You can also call Wellcare Member Services at the numbers listed at the bottom of this page.

If you still do not agree with this decision, you can:

- Ask for an "Independent Medical Review" (IMR) and an outside reviewer that is not related to the health plan will review your case
- Ask for a "State Hearing" and a judge will review your case

You can ask for both an IMR and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first. For example, if you ask for an IMR first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, but the hearing has already taken place, you cannot ask for an IMR. In this case, the State Hearing has the final say.

You will not have to pay for an IMR or State Hearing.

INDEPENDENT MEDICAL REVIEW (IMR)

If you want an IMR, you must ask for one within **180 calendar days** from the date of receiving a "Notice of Appeal Resolution" letter. The paragraph below will provide you with information on how to request an IMR. Note that the term "grievance" is talking about both "complaints" and "appeals."

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone **Health Net** at **1-800-675-6110 (TTY: 711)** and use **Health Net's appeal** process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 calendar days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)**

and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Website **(**www.dmhc.ca.gov**)** has complaint forms, IMR application forms, and instructions online.

STATE HEARING

If you want a State Hearing, you must ask for one within **120 calendar days** from the date of the "Notice of Appeal Resolution" (NAR) informing you that the previous Adverse Benefit Determination is partially or fully upheld. But, **if you are currently getting treatment and you want to continue getting treatment, you must ask for a State Hearing within 10 calendar days** from the date the NAR letter was postmarked or delivered to you, OR before the date your health plan says services will stop. You must say that you want to keep getting treatment when you ask for the State Hearing.

You can ask for a State Hearing by phone or in writing:

- By phone: Call **1-800-952-5253**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- In writing: Fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  On the State Hearing form or in your letter, be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 calendar days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 calendar days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 calendar days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an **"expedited hearing"** and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself or a relative, friend, advocate, doctor, or attorney may speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an "authorized representative."

For questions about complaints and appeals, you can read Chapter 9 of the Wellcare *Member Handbook*. You can also call Wellcare Member Services.

If you have a problem, concern or questions related to your benefits or care, please call Wellcare Member Services.

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at Wellcare Member Services. Phone numbers are the numbers listed at the bottom of this page.
- Or, call the Medi-Cal Customer Service Center at 1-800-841-2900. TTY users may call 1-800-497-4648.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- Or, call the California Department of Health Care Services Fraud & Abuse Hotline at 1-800-822-6222 (TTY:711), or call the Attorney General's Division of Medi-Cal Fraud and Elder Abuse at 1-800-722-0432 (TTY: 711). Your call is free and confidential.

Nondiscrimination Notice

Discrimination is against the law. Wellcare follows State and Federal civil rights laws. Wellcare does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Wellcare provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 Wellcare by calling **1-866-999-3945**. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. If you cannot hear or speak well, please call **TTY 711**. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Wellcare
6261 Katella Ave., # 100
Cypress, CA 90630
1-866-999-3945
TTY: 711

How to File a Grievance

If you believe that Wellcare has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Member Services. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact Member Services by calling **1-866-999-3945**. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. Or, if you cannot hear or speak well, please call **TTY 711**.
- **In writing:** Fill out a complaint form or write a letter and send it to:
  WellCare Health Plans, Inc.
  Grievance Department
  P.O. Box 31384
  Tampa, FL 33631-3384
- **In person:** Visit your doctor's office or Wellcare and say you want to file a grievance.
- **Electronically:** Visit Wellcare's website at **www.wellcare.com/medicare**.

Office of Civil Rights – California Department of Health Care Services

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **1-916-440-7370**. If you cannot speak or hear well, please call **TTY 711 (Telecommunications Relay Service)**.
- **In writing:** Fill out a complaint form or send a letter to:
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Electronically:** Send an email to **CivilRights@dhcs.ca.gov**.

Office of Civil Rights – U.S. Department of Health and Human Services

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- **In writing:** Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.
- **Electronically:** Visit the Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

English: ATTENTION: If you need help in your language call **1-866-999-3945** (TTY: **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-866-999-3945** (TTY: **711**). These services are free of charge.

العربية (Arabic): انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على الرقم **1-866-999-3945** (TTY:**711**). تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على الرقم **1-866-999-3945** (TTY:**711**) . وهذه الخدمات مجانية.

Հայերեն (Armenian). ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե Ձեր լեզվով օգնության կարիք ունեք, զանգահարեք **1-866-999-3945** (TTY՝ **711**): Հասանելի են նաև օգնություն և ծառայություններ հաշմանդամություն ունեցող անձանց համար, ինչպիսիք են՝ բրայլյան և խոշոր տառերով փաստաթղթերը: Զանգահարեք **1-866-999- 3945** (TTY՝ **711**): Այս ծառայություններն անվճար են:

ភាសាខ្មែរ (Cambodian)៖ ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ **1-866-999-3945** (TTY: **711**)។ ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរផុសសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ **1-866-999-3945** (TTY: **711**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃនោះទេ។

中文 (Chinese)：注意：如果您需要以您母語提供的協助，請致電 **1-866-999-3945** (TTY：**711**)。我們也為殘疾人士提供輔助和服務，例如點字和大字體印刷的文件。請致電 **1-866-999-3945** (TTY：**711**)。這些服務為免費服務。

فارسی (Farsi): توجه: اگر نیاز به کمک به زبان خودتان دارید با شماره (TTY: **711**) **1-866-999-3945** تماس بگیرید. کمک‌ها و خدمات برای افراد دارای معلولیت نیز در دسترس است، مانند اسناد با خط بریل و چاپ درشت. با شماره (TTY **711**) **1-866-999-3945** تماس بگیرید. این خدمات رایگان است.

हिंदी (Hindi): ध्यान दें: अगर आपको अपनी भाषा में मदद चाहिए, तो **1-866-999-3945** (TTY: **711**) पर कॉल करें. विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज़ जैसी सहायता और सेवाएं उपलब्ध हैं. **1-866-999-3945** (TTY: **711**) पर कॉल करें. ये सेवाएं नि:शुल्क हैं.

Lus Hmoob (Hmong): TSEEM CEEB: Yog koj xav tau kev pab ua koj hom lus hu rau **1-866-999-3945** (TTY: **711**). Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam rau cov neeg xiam oob qhab, xws li cov ntaub ntawv Ua Ntawv Su thiab cov ntawv loj. Hu rau **1-866-999-3945** (TTY: **711**). Cov kev pab cuam no yog pab dawb xwb.

日本語（Japanese）：注意：言語のヘルプが必要な場合は **1-866-999-3945**（TTY：**711**）までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。**1-866-999-3945**（TTY：**711**）までお電話ください。これらのサービスは無料です。

한국어(Korean): 주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 **1-866-999-3945** (TTY: **711**)번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. **1-866-999-3945**(TTY: **711**)번으로 연락해 주십시오. 해당 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian): ສຳຄັນ: ຖ້າວ່າທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານ ໂທ **1-866-999-3945** (TTY: **711**). ນອກຈາກນີ້ ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ບໍລິການສຳລັບຄົນພິການ ເຊັ່ນ: ເອກະສານທີ່ເປັນຕົວອັກສອນນູນ ແລະ ຕົວພິມຂະໜາດໃຫຍ່ ໂທ **1-866-999-3945** (TTY: **711**). ການບໍລິການເຫຼົ່ານີ້ ແມ່ນຟຣີ

Mienh (Mien): Liouh Eix: Oix se meih oix nongc zuqc gorngv mienh wac daih taengx meih, cingv meih mboqv dienx wac **1-866-999-3945** (TTY: **711**). Yie mbuo hac haih nongc mienh wac daih taengx waic fangx nyei mienh, hnangv zing mangc mv buatc lamh nyei mienh nongc nyei nzangc caux domh nzangc wenh jienx. Cingv meih mboqv dienx wac **1-866-999-3945** (TTY: **711**). Naiv deix bong zouc gong se maiv siou zinh nyanh nyei.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ **1-866-999-3945** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪੰਗਤਾਵਾਂ ਵਾਲੇ ਲੋਕਾਂ ਵਾਸਤੇ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਛਾਪੇ ਵਾਲੇ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। **1-866-999-3945** 'ਤੇ ਕਾਲ ਕਰੋ (TTY: **711**)। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

Русский (Russian): ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру **1-866-999-3945** (TTY: **711**). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру **1-866-999-3945** (TTY: **711**). Эти услуги предоставляются бесплатно.

Español (Spanish): ATENCIÓN: Si necesita ayuda en su idioma llame al **1-866-999-3945** (TTY: **711**). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al **1-866-999-3945** (TTY: **711**). Estos servicios son gratuitos.

Tagalog (Tagalog): PAALALA: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa **1-866-999-3945** (TTY: **711**). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa **1-866-999-3945** (TTY: **711**). Walang bayad ang mga serbisyong ito.

ภาษาไทย (Thai): หมายเหตุ: **หากต้องการความช่วยเหลือในภาษาของคุณ โปรดโทรไปท 1-866-999-3945** (TTY: **711**) **เรามีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารทีเป็นอักษรเบรลล์และเอกสารทีใช้ตัวอักษรขนาดใหญ่ ด้วยเช่นกัน โปรดโทรไปที 1-866-999-3945** (TTY: **711**) **บริการเหล่านีไม่มีค่าใช้จ่าย**

Українська (Ukrainian). УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером **1-866-999-3945** (TTY: **711**). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером **1-866-999-3945** (TTY: **711**). Ці послуги є безкоштовними.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số **1-866-999-3945** (TTY: **711**). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và cỡ chữ lớn cũng được cung cấp. Hãy gọi số **1-866-999-3945** (TTY: **711**). Các dịch vụ này được miễn phí.

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call Wellcare Member Services:

1-866-999-3945
Calls to this number are free. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
Member Services also has free language interpreter services available for non-English speakers.

711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Calls to this number are free. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

If you have questions about your health:

- Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.
- If your PCP's office is closed, you can also call the Nurse Advice Line. A nurse will listen to your problem and tell you how to get care. (Example: urgent care, emergency room). The numbers for the Nurse Advice Line are:

1-800-893-5597
Calls to this number are free. 24 hours a day, 7 days a week.
Wellcare also has free language interpreter services available for non-English speakers.

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Calls to this number are free. 24 hours a day, 7 days a week.