2024
Summary of Benefits

Illinois

Wellcare No Premium (HMO-POS)

H1416 | 009

Wellcare No Premium Value (HMO-POS)

H1416 | 082

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-POS) and Wellcare No Premium Value (HMO-POS) from January 1, 2024 to December 31, 2024.

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 lawfully present in the United States.

Our plans and service areas:
H1416009000 Wellcare No Premium (HMO-POS) includes these counties in Illinois: Champaign, Cook, Kane, Kankakee, Knox, Madison, Peoria, Tazewell, Vermilion, and Will.

H1416082000 Wellcare No Premium Value (HMO-POS) includes these counties in Illinois: Champaign, Cook, Kane, Kankakee, Knox, Madison, Peoria, Tazewell, Vermilion, and Will.

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 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.

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-POS) and Wellcare No Premium Value (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-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Monthly plan premium (includes both medical and drugs)	$0 You must continue to pay your Medicare Part B premium.	$0 You must continue to pay your Medicare Part B premium.
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$2,700 in-network annually $2,700 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.	$2,900 in-network annually $2,900 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.
Inpatient Hospital coverage	**In-Network** For each admission, you pay: • $225 copay per day for days 1 through 8 • $0 copay per day for days 9 through 90 * **Out-of-Network** Days 1-90: 40% coinsurance per admission *	**In-Network** For each admission, you pay: • $225 copay per day for days 1 through 8 • $0 copay per day for days 9 through 90 * **Out-of-Network** Days 1-90: 40% coinsurance per admission *

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Outpatient Hospital coverage Outpatient hospital services	**In-Network** $0 copay for diagnostic colonoscopy. $250 copay for all other outpatient services. * **Out-of-Network** 40% coinsurance for surgical and non-surgical services (includes diagnostic colonoscopy) *	**In-Network** $0 copay for diagnostic colonoscopy. $250 copay for all other outpatient services. * **Out-of-Network** 40% coinsurance for surgical and non-surgical services (includes diagnostic colonoscopy). *
Outpatient hospital observation services	**In-Network** $135 copay for outpatient observation services when you enter observation status through an emergency room. $250 copay for outpatient observation services when you enter observation status through an outpatient facility. **Out-of-Network** 40% coinsurance	**In-Network** $135 copay for outpatient observation services when you enter observation status through an emergency room. $250 copay for outpatient observation services when you enter observation status through an outpatient facility. **Out-of-Network** 40% coinsurance

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Ambulatory surgical center (ASC) services	**In-Network** $175 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $175 copay * **Out-of-Network** 40% coinsurance *
Doctor Visits Primary Care Providers	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 40% coinsurance
Specialists	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
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, COVID shots))	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 40% coinsurance
Emergency care	$135 copay Copay is waived if you are admitted to a hospital within 24 hours.	$135 copay Copay is waived if you are admitted to a hospital within 24 hours.

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Worldwide emergency coverage	$135 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.	$135 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	$0 copay	$0 copay
Worldwide urgent care coverage	$135 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.	$135 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.

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Diagnostic Services/Labs/Imaging Lab services	**In-Network** $0 copay for all other labs. $50 copay for genetic testing. * **Out-of-Network** 40% coinsurance *	**In-Network** $0 copay for all other labs. $50 copay for genetic testing. * **Out-of-Network** 40% coinsurance *
Diagnostic tests and procedures	**In-Network** $0 copay for each Medicare-covered spirometry test and specified testing-related services. $50 copay for all other Medicare-covered diagnostic procedures and tests. * **Out-of-Network** 40% coinsurance *	**In-Network** $0 copay for each Medicare-covered spirometry test and specified testing-related services. $50 copay for all other Medicare-covered diagnostic procedures and tests. * **Out-of-Network** 40% coinsurance *
Outpatient X-rays	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance *

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	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** $0 copay for a diagnostic mammogram. $250 copay for all other diagnostic radiology services received in an outpatient setting. $100 copay for all other services received in all other locations. * **Out-of-Network** 40% coinsurance *	**In-Network** $0 copay for a diagnostic mammogram. $250 copay for all other diagnostic radiology services received in an outpatient setting. $100 copay for all other services received in all other locations. * **Out-of-Network** 40% coinsurance *
Therapeutic Radiology	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *
Hearing services Hearing Exam Medicare Covered	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Routine hearing exam	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year
Hearing Aids Hearing Aid Fitting/Evaluation(s)	**In-Network** $0 copay * **Out-of-Network** Not covered 1 fitting(s) / evaluation(s) every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 fitting(s) / evaluation(s) every year

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Hearing aid allowance All types	Up to a $1,500 allowance per ear every year for hearing aids. **In-Network** $0 copay * **Out-of-Network** Not covered Limited to 2 hearing aid(s) every year	Up to a $1,500 allowance per ear every year for hearing aids. **In-Network** $0 copay * **Out-of-Network** Not covered Limited to 2 hearing aid(s) every year
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.

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Dental services		
Preventive services	**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	**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
Fluoride Treatment	**In-Network** $0 copay * **Out-of-Network** Not covered 1 every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 every year
Comprehensive services Medicare-covered	**In-Network** $10 copay for each Medicare-covered service. * **Out-of-Network** 40% coinsurance for each Medicare-covered service. *	**In-Network** $10 copay for each Medicare-covered service. * **Out-of-Network** 40% coinsurance for each Medicare-covered service. *

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Comprehensive services		
Diagnostic Services	**In-Network** $0 copay *	**In-Network** $0 copay *
	Out-of-Network Not covered	**Out-of-Network** Not covered
Restorative Services	**In-Network** $0 copay *	**In-Network** $0 copay *
	Out-of-Network Not covered	**Out-of-Network** Not covered
Endodontics/ Periodontics/ Extractions	**In-Network** $0 copay *	**In-Network** $0 copay *
	Out-of-Network Not covered	**Out-of-Network** Not covered

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Benefits

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Non-routine services	**In-Network** $0 copay * **Out-of-Network** Not covered	**In-Network** $0 copay * **Out-of-Network** Not covered
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	**In-Network** $0 copay * **Out-of-Network** Not covered **For more information, limitations and exclusions, please see your Evidence of Coverage. Additional dental limitations and exclusions apply.**	**In-Network** $0 copay * **Out-of-Network** Not covered **For more information, limitations and exclusions, please see your Evidence of Coverage. Additional dental limitations and exclusions apply.**
Additional Dental Information	**What you should know:** This plan includes coverage of comprehensive services up to $5,000 per plan year.	**What you should know:** This plan includes coverage of comprehensive services up to $3,000 per plan year.

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Vision Services Eye Exam Medicare Covered	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) $10 copay (all other Medicare-covered eye exams) * **Out-of-Network** 40% coinsurance *	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) $10 copay (all other Medicare-covered eye exams) * **Out-of-Network** 40% coinsurance *
Routine eye exam (Refraction)	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year
Glaucoma screening	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 40% coinsurance for each Medicare-covered service	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 40% coinsurance for each Medicare-covered service

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Eyewear Medicare Covered	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance *
Routine eyewear Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames	**In-Network** $0 copay * **Out-of-Network** Not covered	**In-Network** $0 copay * **Out-of-Network** Not covered
Eyewear allowance	Up to a $400 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.

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Mental Health Services		
Inpatient visit	**In-Network** For each admission, you pay: • $275 copay per day for days 1 through 8 • $0 copay per day for days 9 through 90 * **Out-of-Network** Days 1-90: 40% coinsurance per admission *	**In-Network** For each admission, you pay: • $275 copay per day for days 1 through 8 • $0 copay per day for days 9 through 90 * **Out-of-Network** Days 1-90: 40% coinsurance per admission. *
Outpatient individual therapy visit	**In-Network** $40 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $40 copay * **Out-of-Network** 40% coinsurance *
Outpatient group therapy visit	**In-Network** $40 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $40 copay * **Out-of-Network** 40% coinsurance *

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Skilled nursing facility (SNF)	**In-Network** For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $203 copay per day for days 21 through 40 • $0 copay per day for days 41 through 100 * **Out-of-Network** Days 1-100: 40% coinsurance per benefit period *	**In-Network** For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $203 copay per day for days 21 through 40 • $0 copay per day for days 41 through 100 * **Out-of-Network** Days 1 - 100: 40% coinsurance per benefit period. *
Therapy and Rehabilitation Services Physical Therapy	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Outpatient rehabilitation services provided by an occupational therapist	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *
Pulmonary rehabilitation services	**In-Network** $20 copay **Out-of-Network** 40% coinsurance	**In-Network** $20 copay **Out-of-Network** 40% coinsurance
Ambulance Ground Ambulance	**In-Network** $225 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $225 copay * **Out-of-Network** 40% coinsurance *
Air Ambulance	**In-Network** $225 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $225 copay * **Out-of-Network** 40% coinsurance *
Transportation Services	**In-Network** Not covered	**In-Network** Not covered

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	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
	Out-of-Network Not covered	**Out-of-Network** Not covered
Medicare Part B Drugs		
Chemotherapy and Other Part B Drugs	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance * Certain Part B rebatable drugs may be subject to a lower coinsurance than the amount shown above. The list of Part B rebatable drugs that are subject to a lower coinsurance is published by the Centers for Medicare & Medicaid Services (CMS) and may change quarterly.	**In-Network** 20% coinsurance * **Out-of-Network** 20% coinsurance * Certain Part B rebatable drugs may be subject to a lower coinsurance than the amount shown above. The list of Part B rebatable drugs that are subject to a lower coinsurance is published by the Centers for Medicare & Medicaid Services (CMS) and may change quarterly.

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Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Insulin	**In-Network** $35 copay (maximum per month) * **Out-of-Network** $35 copay (maximum per month) *	**In-Network** $35 copay (maximum per month) * **Out-of-Network** $35 copay (maximum per month) *
Allergy Antigen	**In-Network** 0% coinsurance * **Out-of-Network** 0% coinsurance *	**In-Network** 0% coinsurance * **Out-of-Network** 0% coinsurance *

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Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H1416, Plan 009		Wellcare No Premium Value (HMO-POS) H1416, Plan 082	
Stage 1: Annual Prescription Deductible				
Deductible	This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.		This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.	
Stage 2: Initial Coverage (after you pay your deductible, if applicable)				
You pay the following until your total yearly drug costs reach $5,030. 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.				
Important Message About What You Pay for Vaccines: 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).				
Important Message About What You Pay for Insulin: You won't pay more than $35 for up to a one-month supply, $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you have not paid your deductible (if your plan has a deductible).				
Retail cost-sharing (30-day/Up to a 100-day supply)				
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic Drugs) includes preferred generic drugs and may include some brand drugs.	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay
Tier 2 (Generic Drugs) includes generic drugs and may include some brand drugs	$5 / $15 copay	$10 / $30 copay	$5 / $15 copay	$10 / $30 copay

Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H1416, Plan 009		Wellcare No Premium Value (HMO-POS) H1416, Plan 082	
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 3 (Preferred Brand Drugs) includes preferred brand drugs and may include some generic drugs.	$42 / $126 copay	$47 / $141 copay	$42 / $126 copay	$47 / $141 copay
Tier 4 (Non-Preferred Drugs) includes non-preferred brand and non-preferred generic drugs.	45% / 45% coinsurance	45% / 45% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance
Tier 5 (Specialty Tier) includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available
Tier 6 (Select Care Drugs) includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines)	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay

Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H1416, Plan 009		Wellcare No Premium Value (HMO-POS) H1416, Plan 082	
Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)				
Mail-order cost-sharing (30-day/Up to a 100-day supply)				
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic Drugs) includes preferred generic drugs and may include some brand drugs.	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay
Tier 2 (Generic Drugs) includes generic drugs and may include some brand drugs	$5 / $0 copay	$10 / $30 copay	$5 / $0 copay	$10 / $30 copay
Tier 3 (Preferred Brand Drugs) includes preferred brand drugs and may include some generic drugs.	$42 / $84 copay	$47 / $141 copay	$42 / $84 copay	$47 / $141 copay
Tier 4 (Non-Preferred Drugs) includes non-preferred brand and non-preferred generic drugs.	45% / 45% coinsurance	45% / 45% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance

Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H1416, Plan 009		Wellcare No Premium Value (HMO-POS) H1416, Plan 082	
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 5 (Specialty Tier) includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available
Tier 6 (Select Care Drugs) includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines)	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay
Stage 3: Coverage Gap				
	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap. Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You won't pay more than $35 for a one-month supply of each		After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap. Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You won't pay more than $35 for a one-month supply of each	

Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H1416, Plan 009		Wellcare No Premium Value (HMO-POS) H1416, Plan 082	
	Preferred	**Standard**	**Preferred**	**Standard**
	covered insulin product regardless of the cost-sharing tier.		covered insulin product regardless of the cost-sharing tier.	
Stage 4: Catastrophic Coverage				
	You enter this stage after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year. During this payment stage, the plan pays all of the cost for your covered drugs.		You enter this stage after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year. During this payment stage, the plan pays all of the cost for your covered drugs.	

Generic drugs may be covered on tiers other than Tier 1 and Tier 2. Please check the 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 (100-day supply).

Excluded Drugs:

Wellcare No Premium (HMO-POS) and Wellcare No Premium Value (HMO-POS) includes enhanced drug coverage of certain excluded drugs, such as Tier 1 folic acid, vitamin B12, vitamin D2, generic-only sildenafil and vardenafil. Generic sildenafil and vardenafil 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-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Chiropractic Services Medicare-covered	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *
Acupuncture Medicare-covered	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. $10 copay for Medicare-covered Acupuncture received in a Chiropractor office. $10 copay for Medicare-covered Acupuncture received in a Specialist office. * **Out-of-Network** 40% coinsurance *	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. $10 copay for Medicare-covered Acupuncture received in a Chiropractor office. $10 copay for Medicare-covered Acupuncture received in a Specialist office. * **Out-of-Network** 40% coinsurance *

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Podiatry Services (Foot Care) Medicare Covered	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $10 copay * **Out-of-Network** 40% 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** 20% coinsurance * **Out-of-Network** 40% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Meals		
Post-Acute Meals	$0 copay ▪ **What you should know:** You pay nothing for home delivered 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 home delivered 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.
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.

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Medical Equipment/Supplies		
Durable Medical Equipment (DME)	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *
Prosthetics	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *
Diabetic supplies	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance * For more information, limitations and exclusions, please see your Evidence of Coverage.	**In-Network** $0 copay * **Out-of-Network** 40% coinsurance * For more information, limitations and exclusions, please see your Evidence of Coverage.

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Diabetic therapeutic shoes or inserts	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 40% coinsurance *
Opioid treatment program services	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *	**In-Network** $10 copay * **Out-of-Network** 40% coinsurance *
Wellness Programs Fitness	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. $0 copay	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. $0 copay

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
	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 **Out-of-Network** Not covered Limited to 5 visit(s) every year	**In-Network** $0 copay **Out-of-Network** Not covered Limited to 5 visit(s) every year

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
Annual Physical Exam	**In-Network** $0 copay **Out-of-Network** Not covered **What you should know:** The exam includes a detailed medical/family history and recommendations for preventive screenings/care.	**In-Network** $0 copay **Out-of-Network** Not covered **What you should know:** The exam includes a detailed medical/family history and recommendations for preventive screenings/care.
24-Hour Nurse Advice Line	$0 copay	$0 copay
Personal emergency medical response device (PERS)	$0 copay	$0 copay
Over-the-Counter (OTC) Items	Please see the Wellcare Spendables™ section for more information about the over-the-counter (OTC) benefit.	Please see the Wellcare Spendables™ section for more information about the over-the-counter (OTC) benefit.
Wellcare Spendables™	You will receive $67 **monthly** ($804 per year) preloaded on your Wellcare Spendables™ card. Your monthly allowance **rolls over to the following month if unused and expires at end of the plan year.** Your card allowance can be used towards:	You will receive $57 **monthly** ($684 per year) preloaded on your Wellcare Spendables™ card. Your monthly allowance **rolls over to the following month if unused and expires at end of the plan year.** Your card allowance can be used towards:

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H1416, Plan 009	Wellcare No Premium Value (HMO-POS) H1416, Plan 082
	Over-the-Counter items (OTC) - Your card can be used at participating retail locations, via mobile app, or log in to your member portal to place an order for home delivery. Examples of covered items include brand name and generic over-the-counter items, vitamins, pain relievers, cold and allergy items and diabetic items. **Dental, Vision, and Hearing** - You may use your card to help reduce your out-of-pocket expenses for any dental, vision, and/or hearing services. The card may be used to pay your dental, vision, or hearing provider directly. For more information, limitations and exclusions, please see your Evidence of Coverage.	**Over-the-Counter items (OTC) -** Your card can be used at participating retail locations, via mobile app, or log in to your member portal to place an order for home delivery. Examples of covered items include brand name and generic over-the-counter items, vitamins, pain relievers, cold and allergy items and diabetic items. **Dental, Vision, and Hearing** - You may use your card to help reduce your out-of-pocket expenses for any dental, vision, and/or hearing services. The card may be used to pay your dental, vision, or hearing provider directly. For more information, limitations and exclusions, please see your Evidence of Coverage.

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

Multi-Language Insert
Multi-language Interpreter Services

Form Approved
OMB# 0938-1421

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at the plan numbers on the following pages. Someone who speaks English/Language can help you. This is a free service.

Spanish: Contamos con los servicios gratuitos de un intérprete para responder las preguntas que tenga sobre nuestro plan de salud o de medicamentos. Para solicitar un intérprete, simplemente llámenos a los números del plan que figuran en las siguientes páginas. Alguien que habla español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的口译服务，可解答您对我们的健康或药物计划的有关疑问。如需译员，请拨打以下页面上的计划号码联系我们。您将获得讲汉语普通话的译员的帮助。这是一项免费服务。

Chinese Cantonese: 我們提供免費的口譯服務，可解答您對我們的健康或藥物計劃可能有的任何疑問。如需口譯員服務，請致電下頁的計劃電話號碼。會說廣東話的人員可以幫助您。此為免費服務。

Tagalog: May mga libre kaming serbisyo ng interpreter para sagutin ang anumang posible ninyong tanong tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang kami sa mga numero ng plano na nasa mga sumusunod na pahina. May makakatulong sa inyo na nagsasalita ng Tagalog. Isa itong libreng serbisyo.

French: Nous proposons des services d'interprètes gratuits pour répondre à toutes vos questions sur notre régime de santé ou de médicaments. Pour obtenir les services d'un interprète, il suffit de nous appeler aux numéros figurant sur les pages suivantes. Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào về chương trình sức khỏe hoặc chương trình thuốc của chúng tôi. Để nhận thông dịch viên, chỉ cần gọi chúng tôi theo số điện thoại chương trình ở các trang sau. Một nhân viên nói tiếng Việt có thể giúp quý vị. Dịch vụ này được miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetschservice, wenn Sie Fragen zu unseren Gesundheits- oder Medikamentenplänen haben. Wenn Sie einen Dolmetscher brauchen, rufen Sie eine der Telefonnummern auf den folgenden Seiten an. Ein deutschsprachiger Mitarbeiter wird Ihnen behilflich sein. Dieser Service ist kostenlos.

Korean: 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우 다음 페이지에 있는 플랜 번호로 연락해 주십시오. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

Russian: Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, вам доступны бесплатные услуги переводчика. Если вам нужен переводчик, просто позвоните нам по номерам, представленным на следующих страницах. Вам окажет помощь сотрудник, говорящий на русском языке. Данная услуга бесплатна.

Arabic: نوفّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على أرقام الخطة التي تظهر في الصفحات التالية. يمكن أن يساعدك شخص يتحدث العربية. وتتوفر هذه الخدمة بشكل مجاني.

Hindi: हमारे स्वास्थ्य या ड्रग प्लान के बारे में आपके किसी भी सवाल का जवाब देने के लिए, हम मुफ़्त में दुभाषिया सेवाएं देते हैं। दुभाषिया सेवा पाने के लिए, बस हमें अगले पेज पर दिए गए प्लान नंबर पर कॉल करें। हिन्दी में बात करने वाला सहायक आपकी मदद करेगा। यह एक निःशुल्क सेवा है।

Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare i numeri del piano riportati nelle pagine seguenti. Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através dos números do plano nas páginas seguintes. Um falante de português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon tradiktè nan bouch, annik rele nimewo yo pou plan an ki make sou paj ki annapre yo. Yon moun ki pale Kreyòl Ayisyen ka ede w. Se yon sèvis gratis.

Form Approved
OMB# 0938-1421

Polish: Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod podany na kolejnych stronach numer odnoszący się do planu. Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

Japanese: 弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、次からのページに記載されている弊社の計画担当の電話番号にお問い合わせください。日本語の通訳担当者が対応します。これは無料のサービスです。

ALABAMA

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

ARIZONA

PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

ARKANSAS

HMO, HMO-POS, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO-POS D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

CALIFORNIA

HMO
1-866-999-3945 (TTY: 711)
wellcare.com/medicare

CONNECTICUT

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

FLORIDA

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

GEORGIA

HMO, HMO-POS, HMO D-SNP, PPO,
PPO D-SNP
1-866-892-8340 (TTY: 711)
wellcare.com/medicare

HAWAII

HMO, PPO, HMO D-SNP
1-877-457-7621 (TTY: 711)
wellcare.com/ohana

ILLINOIS

Wellcare Assist Compass (HMO),
Wellcare Giveback Open (PPO),
Wellcare No Premium (HMO-POS),
Wellcare No Premium Open (PPO),
Wellcare No Premium Value (HMO-POS)
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

Wellcare No Premium Essential (HMO),
Wellcare No Premium Essential Value (HMO),
Wellcare No Premium Exclusive (HMO)
1-866-892-8340 (TTY: 711)
wellcare.com/medicare

KENTUCKY

HMO, HMO-POS, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

LOUISIANA

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

MAINE

HMO, PPO, PFFS
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

MASSACHUSETTS

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

MICHIGAN

HMO, HMO-POS, PPO, HMO D-SNP,
HMO-POS D-SNP, PPO D-SNP
1-866-892-8340 (TTY: 711)
wellcare.com/medicare

MISSOURI

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

MISSISSIPPI

HMO, HMO-POS, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

NEW HAMPSHIRE

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

NEW JERSEY

HMO, HMO-POS, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

NEW YORK

HMO, PPO, PFFS
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

NORTH CAROLINA

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

OHIO

HMO, HMO-POS, HMO D-SNP, HMO-POS D-SNP
1-866-892-8340 (TTY: 711)
wellcare.com/medicare

RHODE ISLAND

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

SOUTH CAROLINA

HMO, HMO-POS, PPO, HMO D-SNP, PPO D-SNP
1-866-892-8340 (TTY: 711)
wellcare.com/medicare

TENNESSEE

HMO, HMO-POS, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

TEXAS

HMO, HMO-POS, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

VERMONT

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

WASHINGTON

HMO, PPO
1-833-444-9088 (TTY: 711)
wellcare.com/medicare

HMO D-SNP, PPO D-SNP
1-833-444-9089 (TTY: 711)
wellcare.com/medicare

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 Customer Service 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, 2025.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ **For 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 situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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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

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.