

# Summary of Benefits



## **Medicare Advantage and Part D**

**Plan year:** January 1 – December 31, 2026

### **Tennessee**

All counties in Tennessee

## **Wellpoint Full Dual Advantage 2 (HMO D-SNP)**

# Introduction

This document is a brief summary of the benefits and services covered by Wellpoint Full Dual Advantage 2 (HMO D-SNP). 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 Wellpoint Full Dual Advantage 2 (HMO D-SNP). Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage*.

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## A. Disclaimers

This is a summary of health services covered by Wellpoint Full Dual Advantage 2 (HMO D-SNP) for January 1 – December 31, 2026. This is only a summary. Please read the *Evidence of Coverage* for the full list of benefits. You may contact Member Services at the phone number listed below to request your Evidence of Coverage. You can also access your *Evidence of Coverage* at the plan's website listed on the bottom of this page.

- Wellpoint Tennessee, Inc. is an HMO D-SNP plan with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in Wellpoint Tennessee, Inc. depends on contract renewal. Services provided by Wellpoint Tennessee, Inc.
- 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](http://www.medicare.gov)) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- For more information about TennCare you can check the Members/Applicant section of the TennCare website at [www.tn.gov/TennCare](http://www.tn.gov/TennCare) or call 1-800-342-3145. For people who have both Medicare and TennCare you can contact TennCare Connect at 1-855-259-0701 or 1-800-848-0298 TTY, Monday – Friday 7 a.m. to 6 p.m. CST. Or use the free TennCare Connect member portal at: [www.tenncareconnect.tn.gov](http://www.tenncareconnect.tn.gov).

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-833-713-1074** (TTY: **711**) or speak to your provider. Hours of operation are 8 a.m. to 8 p.m. local time, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

**Spanish – ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente o hable con su proveedor. El horario de atención es de 8 a.m. a 8 p.m. hora local, los siete días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.º de octubre hasta el 31 de marzo, y de lunes a viernes (excepto los días feriados) desde el 1.º de abril hasta el 30 de septiembre.

**Amharic – ያስተውሉ:-** አማርኛ የሚናገሩ ከሆነ፣ገንዘብ የቋንቋ እርዳታ አገልግሎቶች ለእርስዎ ይገኛሉ። መረጃን በተደራሽ ቅርጾች ለማቅረብ አግባብ የሆኑ ረዳት መረጃዎች እና አገልግሎቶችም በገንዘብ ይገኛሉ። ከላይ በተጠቀሰው ስልክ ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። የስራ ሰዓቶች ከጠዋቱ 8 ሰዓት እስከ ከሰዓት 8 ሰዓት የአካባቢ ሰዓት፣ በሰዎች ሰባት ቀናት (ከምስጋና እና የገና በዓላት በስተቀር) ከኦክቶበር 1 እስከ ሚያዝያ 31፣ እና ከሰኞ እስከ አርብ (ከበዓላት በስተቀር) ከሚያዝያ 1 እስከ ሴፕቴምበር 30 ናቸው።

**Arabic** تنبيه: إذا كنت تتحدث ،العربيةفإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانًا. اتصل برقم الهاتف المذكور أعلاه أو تحدث إلى مقدم الخدمة الخاص بك. ساعات العمل من الساعة 8 صباحًا حتى الساعة 8 مساءً على مدار الأسبوع (ما عدا أيام عيد الشكر وعيد الميلاد) بداية من 1 أكتوبر حتى 31 مارس ومن الاثنين حتى الجمعة (ما عدا أيام العطلات) من 1 أبريل حتى 30 سبتمبر.

**Bengali – মনোযোগ দিন:** যদি আপনি বাংলা ভাষায় কথা বলেন, তবে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। তথ্য সহজলভ্য ফরম্যাটে পাওয়ার জন্য প্রয়োজনীয় সহায়ক সরঞ্জাম ও পরিষেবাও বিনামূল্যে প্রদান করা হয়। উপরে উল্লেখিত ফোন নম্বরে ফোন করুন অথবা আপনার পরিষেবা সরবরাহকারীর সাথে কথা বলুন। কার্যক্রমের সময় সকাল ৮ টা থেকে রাত ৮ টা পর্যন্ত (স্থানীয় সময় অনুযায়ী), সপ্তাহে সাত দিন (শুধুমাত্র থ্যাংকসগিভিং ও বড়দিন ছাড়া) অক্টোবর ১ থেকে মার্চ ৩১ পর্যন্ত এবং এপ্রিল ১ থেকে সেপ্টেম্বর ৩০ পর্যন্ত সোমবার থেকে শুক্রবার (ছুটির দিন ছাড়া) কার্যক্রম পরিচালিত হয়।

**Chinese Simplified** – 注意：如果您说简体中文，我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，以可访问的格式提供信息。请拨打上面列出的电话号码或与您的提供者交谈。营业时间：10月1日至3月31日，每周七天（感恩节和圣诞节除外），4月1日至9月30日，周一至周五（节假日除外），当地时间上午8时至晚上8时。

**Chinese Traditional** – 注意：如果您說繁體中文，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼或與您的提供者交談。營業時間：10月1日至3月31日，每週七天（感恩節和耶誕節除外），4月1日至9月30日，週一至週五（節假日除外），當地時間上午8時至晚上8時。

**Farsi** توجه: اگر به زبان فارسی صحبت می کنید خدمات کمک زبانی رایگان قابل ارائه به شما است. وسایل و خدمات کمکی مناسب برای ارائه اطلاعات در قالبهای مناسب معلولان نیز به صورت رایگان قابل ارائه است. با شماره تلفن بالا تماس بگیرید یا با ارائه دهندگان صحبت کنید. ساعات کاری: از 8 صبح تا 8 شب به وقت محلی از 1 اکتبر تا 31 مارس (به جز کریسمس و روز شکرگزاری) در هفت روز هفته و از 1 آوریل تا 30 سپتامبر از دوشنبه تا جمعه (به جز تعطیلات).

**French – ATTENTION** : Si vous parlez français, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus ou appelez votre prestataire. Les heures d'ouverture sont de 8 a.m à 8 p.m., heure locale, sept jours sur sept (sauf Thanksgiving et Noël) du 1er octobre au 31 mars, et du lundi au vendredi (sauf jours fériés) du 1er avril au 30 septembre.

**German – ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die oben aufgeführte Telefonnummer an oder wenden Sie sich an Ihren Anbieter. Die Geschäftszeiten sind 8 Uhr bis 20 Uhr lokaler Zeit an sieben Tagen in der Woche (außer Thanksgiving und Weihnachten) vom 1. Oktober bis zum 31. März, und Montag bis Freitag (außer an Feiertagen) vom 1. April bis zum 30. September.

**Gujarati – ધ્યાન આપો:** જો તમે ગુજરાતી બોલો છો, તો તમારા માટે વિના મૂલ્યે ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોનમેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. ઉપર દર્શાવેલ ફોન નંબર પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. કામકાજના કલાકો સ્થાનિક સમય મુજબ સવારે 8 વાગ્યાથી સાંજના 8 વાગ્યા સુધી, ઓક્ટોબર 1 થી માર્ચ 31 સુધી અઠવાડિયાના સાતેય દિવસ (થેક્સગિવિંગ અને ક્રિસમસ સિવાય) અને સોમવારથી શુક્રવાર (રજાઓ સિવાય) એપ્રિલ 1 થી સપ્ટેમ્બર 30 સુધી છે. –  
ה-30 ספטמבר - 1 באפריל (מחול - 1 באפריל)

**Hindi – ध्यान दें:** यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। पहुँच योग्य प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। ऊपर दिए गए फ़ोन नंबर पर कॉल करें या अपने प्रदाता से बात करें। कामकाज के घंटे, 1 अक्टूबर से 31 मार्च तक सप्ताह के सातों दिन (थैंक्सगिविंग और क्रिसमस को छोड़कर), और 1 अप्रैल से 30 सितंबर तक सोमवार से शुक्रवार (छुट्टियों को छोड़कर), स्थानीय समय अनुसार सुबह 8 बजे से रात 8 बजे तक हैं।

**Japanese – 注意：**日本語を話せる方向けに、無料の言語支援サービスをご提供しています。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらでも無料でご利用いただけます。必要な情報取得にお役立てください。上記の電話番号にお電話いただくか、プロバイダーにお問い合わせください。営業時間は、10月1日から3月31日までは現地時間午前8時から午後8時まで週7日（感謝祭とクリスマスを除く）、および4月1日から9月30日まで（祝日を除く）は月曜日から金曜日までです。

**Korean** – 주의: 한국어를 구사하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 위의 전화 번호로 전화하시거나 담당 의료 제공자에게 문의해 주십시오. 운영 시간은 현지 시간 오전 8시부터 오후 8시까지이며 10월 1일부터 3월 31일까지는 주 7일(추수 감사절과 성탄절은 제외) 내내, 4월 1일부터 9월 30일까지는 월요일부터 금요일까지(휴일은 제외)입니다.

**Laotian** – ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ນອກຈາກນີ້ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທົດແທນສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດ ເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທລະສັບທີ່ລະບຸໄວ້ຂ້າງເທິງ ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. ເວລາເຮັດວຽກແມ່ນ 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ ຕາມເວລາໃນທ້ອງຖິ່ນ, ເຈັດມື້ຕໍ່ອາທິດ (ຍົກເວັ້ນວັນຂອບໃຈເພະເຈົ້າ ແລະ ວັນຄຣິດສະມາດ) ຕັ້ງແຕ່ວັນທີ 1 ຕຸລາ ຫາ ວັນທີ 31 ມີນາ, ແລະ ວັນຈັນ ເຖິງ ວັນສຸກ (ຍົກເວັ້ນວັນພັກ) ຕັ້ງແຕ່ວັນທີ 1 ເມສາ ຫາ 30 ກັນຍາ

**Portuguese** – ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado ou fale com o seu fornecedor. Horário de expediente: das 8h às 20h, (hora local), sete dias por semana (exceto Dia de Ação de Graças e Natal) de 1 de outubro até 31 de março, e de segunda a sexta-feira (exceto feriados) de 1 de abril até 30 de setembro.

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона или обсудите этот вопрос с вашим поставщиком услуг. Часы работы: с 08:00 до 20:00 в любой день недели (кроме Дня благодарения и Рождества) с 1 октября по 31 марта и с понедельника по пятницу (кроме праздничных дней) с 1 апреля по 30 сентября.

**Serbian – ПАЗИЊА:** Ако говорите српски, доступне су вам бесплатне услуге помоћи за ваш језик. Бесплатно су вам доступна и одговарајућа помагала и услуге у доступним форматима како бисте добили информације које су вам потребне. Позовите број телефона наведен изнад или поразговарајте са својим пружаоцем услуга. Радно време је од 8 до 20 часова по локалном времену, седам дана у недељи (осим Дана захвалности и Божића) од 1. октобра до 31. марта, односно од понедељка до петка (осим празника) од 1. априла до 30. септембра.

**Tagalog – PAUNAWA:** Kung nagsasalita ka Tagalog, mayroong available na mga libreng serbisyo sa tulong sa wika para sa iyo. Ang naaangkop na mga karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay available rin nang walang bayad. Tawagan ang numero ng telepono na nakalista sa itaas o makipag-usap sa iyong provider. Ang mga oras ng opisina ay 8 a.m. hanggang 8 p.m., lokal na oras, pitong araw sa isang linggo (maliban sa Thanksgiving at Pasko) mula Oktubre 1 hanggang Marso 31, at Lunes hanggang Biyernes (maliban sa mga holiday) mula Abril 1 hanggang Setyembre 30.

**Telugu – గమనీక:** మీరు తొలుగులో మాట్లాడదలచుకుంటే కనుక, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు, సేవలు కూడా ఉచితంగా లభిస్తాయి. పైన జాబితాలో తలిపిన ఫోన్ నంబర్ కు కాల్ చేయండి లేదా మీ ప్లైడ్ డైరెక్ట్ మాట్లాడండి. పని వేళలు అక్టోబర్ 1 నుండి మార్చి 31 వరకు వారానికి ఏడు రోజులు (థంక్స్ గివింగ్, క్రిస్మస్ మినహా) పాటు, ఏప్రిల్ 1 నుండి సెప్టెంబర్ 30 వరకు సోమవారం నుండి శుక్రవారం వరకు (సోలమలు మినహా) సోమనీక సమయం ఉదయం 8 గంటల నుండి రాత్రి 8 గంటల వరకు.

**Vietnamese** – CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên hoặc nói chuyện với nhà cung cấp của quý vị. Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ địa phương, bảy ngày một tuần (Trừ Lễ Tạ ơn và Giáng sinh) từ ngày 1 Tháng Mười đến 31 Tháng Ba, và Thứ Hai đến Thứ Sáu (trừ các ngày lễ), từ ngày 1 Tháng Tư đến 30 Tháng Chín.

- You can get this document for free in other formats, such as large print, accessible electronic documents, language translations or audio. Call **1-833-713-1074 (TTY: 711)**, 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.
- This document is available for free in Spanish, Amharic, Arabic, Bengali, Chinese, Farsi, French, German, Gujarati, Hindi, Japanese, Korean, Laotian, Portuguese, Russian, Serbian, Tagalog, Telugu, and Vietnamese.
- We have free translation services for your member materials, like if you need a letter from us in a different language. Member materials are available at a minimum in Spanish and Arabic.
- If you don't understand a letter from us or your services, call your Care Coordinator. They can talk to you about your problems and try to help you with your issues. This is a free service to you.
- Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits.

- If you call us to request a change to your preferred language or format preference, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at **<https://shop.wellpoint.com/medicare>**.
- Contact Wellpoint Full Dual Advantage 2 (HMO D-SNP) at the phone number listed at the bottom of this page if there are any changes in your personal information, such as your address or phone number.
- The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. You have received this card as a gratuity without the payment of any monetary value or consideration.

## B. Frequently asked questions (FAQ)

The following table lists frequently asked questions.

| Frequently Asked Questions                                                    | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What's a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)?</b> | <p>Wellpoint Full Dual Advantage 2 (HMO D-SNP) is a Medicare Advantage plan. This is a Fully Integrated Dual Eligible Special needs plan (FIDE D-SNP), which means it coordinates all of your Medicare, Medicaid, and prescription drug benefits – including extra benefits and services – in one plan.</p> <p>To be eligible to enroll in a FIDE SNP in Tennessee, you must be entitled to Medicare Parts A and enrolled in Medicare Part B, TennCare (the state's Medicaid program) and you must also be enrolled in CHOICES Groups 1, 2, and 3 with Wellpoint. You must live in the plan's service area.</p> <p>Because you get assistance from TennCare, you pay nothing for your covered services as long as you follow our plan's rules. Refer to Chapter 3 of your <i>Evidence of Coverage</i> for details about the plan's rules.</p> <p>Our plan combines your Medicaid home care and long-term care services and your Medicare services. It also has care coordinators to help you manage all of your providers and services and supports. They all work together to provide the care you need.</p> |

| Frequently Asked Questions                                                                                                      | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Will I get the same Medicare and TennCare benefits in Wellpoint Full Dual Advantage 2 (HMO D-SNP) that I get now?</b></p> | <p>You'll get most of your covered Medicare and TennCare benefits directly from Wellpoint Full Dual Advantage 2 (HMO D-SNP). You'll 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 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, specialty mental health and substance use disorder services, or regional center services.</p> <p>When you enroll in Wellpoint Full Dual Advantage 2 (HMO D-SNP), you and your care team will work together to develop an Individualized Care Plan (ICP) that addresses your health and support needs and reflects your personal preferences and goals.</p> <p>If you're taking any Medicare Part D drugs that Wellpoint Full Dual Advantage 2 (HMO D-SNP) doesn't normally cover, you can get a temporary supply. We'll help you to transition to another drug or get an exception for Wellpoint Full Dual Advantage 2 (HMO D-SNP) to cover your drug if medically necessary. For more information, call Member Services at the numbers listed at the bottom of this page.</p> |

## Frequently Asked Questions

## Answers

### Can I use the same doctors I use now?

This is often the case. If your providers (including doctors, hospitals, therapists, pharmacies, and other health care providers) work with Wellpoint Full Dual Advantage 2 (HMO D-SNP) 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 Wellpoint Full Dual Advantage 2 (HMO D-SNP)’s network. If you use providers or pharmacies that aren’t 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 Wellpoint Full Dual Advantage 2 (HMO D-SNP)’s plan.
- ☐ If you are currently under treatment with a provider that is out of Wellpoint Full Dual Advantage 2 (HMO D-SNP)’s network and have an established relationship with a provider that is out of Wellpoint Full Dual Advantage 2 (HMO D-SNP)’s network, call Member Services to check about staying connected and ask for continuity of care. You can continue with the doctors you use now for up to 12 months for Medicare-covered services and up to 30 days for TennCare covered services. You will be notified within 30 calendar days before the end of your continuity of care period to transition you care to an in-network provider. Contact Member Services to request “Continuity of Care” at the number listed at the bottom of this page.

To find out if your providers are in the plan’s network, call Member Services at the number at the bottom of this page or read Wellpoint Full Dual Advantage 2 (HMO D-SNP)’s Provider and Pharmacy Directory on the plan’s website at [shop.wellpoint.com/medicare](https://shop.wellpoint.com/medicare).

If Wellpoint Full Dual Advantage 2 (HMO D-SNP) is new for you, we’ll work with you to develop an Individualized Plan of Care to address your needs.

| Frequently Asked Questions                                                                                                  | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What's a Wellpoint Full Dual Advantage 2 (HMO D-SNP) care coordinator?</b>                                               | A Wellpoint Full Dual Advantage 2 (HMO D-SNP) 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.                                                                                                                                                                                                                                              |
| <b>What are Long-term Services and Supports (LTSS)?</b>                                                                     | Long Term Services and Support (LTSS) 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. |
| <b>What happens if I need a service but no one in Wellpoint Full Dual Advantage 2 (HMO D-SNP)'s network can provide it?</b> | Most services will be provided by our network providers. If you need a service that can't be provided within our network, Wellpoint Full Dual Advantage 2 (HMO D-SNP) will pay for the cost of an out-of-network provider.                                                                                                                                                                                                                          |

| Frequently Asked Questions                                     | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Where's Wellpoint Full Dual Advantage 2 (HMO D-SNP) available? | <p>The service area for this plan includes:</p> <p>Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson counties, Tennessee.</p> <p>You must live in one of these areas to join the plan.</p> |

| Frequently Asked Questions  | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What's prior authorization? | <p>Prior authorization means an approval from Wellpoint Full Dual Advantage 2 (HMO D-SNP) to seek services outside of our network or to get services not routinely covered by our network <b>before</b> you get the services. Wellpoint Full Dual Advantage 2 (HMO D-SNP) may not cover the service, procedure, item, or drug if you don't get prior authorization.</p> <p><b>If you need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first.</b> Wellpoint Full Dual Advantage 2 (HMO D-SNP) can provide you or your provider a list of services or procedures that require you to get prior authorization from Wellpoint Full Dual Advantage 2 (HMO D-SNP) before the service is provided.</p> <p>Refer to <b>Chapter 3</b> of the <i>Evidence of Coverage</i> to learn more about prior authorization. Refer to the Benefits Chart in <b>Chapter 4</b> of the <i>Evidence of Coverage</i> to learn which services require a prior authorization.</p> <p>If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services at the number listed at the bottom of this page for help.</p> |
| What's a referral?          | <p>A referral means that your primary care provider (PCP) must give you approval to go to someone that's not your PCP. A referral is different than a prior authorization. If you don't get a referral from your PCP, Wellpoint Full Dual Advantage 2 (HMO D-SNP) may not cover the services. Wellpoint Full Dual Advantage 2 (HMO D-SNP) can provide you with a list of services that require you to get a referral from your PCP before the service is provided.</p> <p>Refer to the <i>Evidence of Coverage</i> Chapter 3, Section 2.2, to learn more about when you'll need to get a referral from your PCP.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| Frequently Asked Questions                                                                                                                    | Answers                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Do I pay a monthly amount (also called a premium) under Wellpoint Full Dual Advantage 2 (HMO D-SNP)?</b>                                   | No. Because you have Medical Assistance (Medicaid), you won't pay any monthly premiums for your health coverage. However, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medical Assistance (Medicaid) or another third party. |
| <b>Do I pay a deductible as a member of Wellpoint Full Dual Advantage 2 (HMO D-SNP)?</b>                                                      | No. You don't pay deductibles in Wellpoint Full Dual Advantage 2 (HMO D-SNP).                                                                                                                                                                                                       |
| <b>What's the maximum out-of-pocket amount that I'll pay for medical services as a member of Wellpoint Full Dual Advantage 2 (HMO D-SNP)?</b> | There's no cost sharing for medical services in Wellpoint Full Dual Advantage 2 (HMO D-SNP), 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)                                                                                                                  |
|------------------------------------------------------------|-------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>You need hospital care (continued on the next page)</b> | Inpatient hospital stay | <b>\$0</b>                          | Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 |

**If you have questions**, please call Wellpoint Full Dual Advantage 2 (HMO D-SNP) at **1-844-615-5445** (TTY 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. For more information, visit [shop.wellpoint.com/medicare](https://shop.wellpoint.com/medicare).

| Health need or concern                                | Services you may need                                                                    | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>You need hospital care (continued)</b>             |                                                                                          |                                     | <p>days, you can use these extra days. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>Except in an emergency, your health care provider must tell the plan of your hospital admission.</p> <p>This benefit is covered when you have full Medicaid eligibility. Prior authorization may be required.</p> |
|                                                       | Outpatient hospital services, including observation                                      | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                    |
|                                                       | Ambulatory surgical center (ASC) services                                                | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                    |
|                                                       | Doctor or surgeon care                                                                   | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                    |
| <b>You want a doctor (continued on the next page)</b> | Visits to treat an injury or illness                                                     | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                    |
|                                                       | Care to keep you from getting sick, such as flu shots and screenings to check for cancer | <b>\$0</b>                          |                                                                                                                                                                                                                                                                                                                                                                         |
|                                                       | Wellness visits, such as a physical                                                      | <b>\$0</b>                          |                                                                                                                                                                                                                                                                                                                                                                         |

| Health need or concern                                      | Services you may need                                  | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------|--------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>You want a doctor (continued)</b>                        | “Welcome to Medicare” (preventive visit one time only) | <b>\$0</b>                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                             | Specialist care                                        | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>You need emergency care (continued on the next page)</b> | Emergency room services                                | <b>\$0</b>                          | <p>You may use any emergency room if you reasonably believe you need emergency care. You do not need prior authorization and you do not have to be in-network.</p> <p>In addition to the Medicare-covered emergency room services, this plan offers worldwide emergency care services when traveling outside of the United States and its territories for less than six months. Coverage is limited to <b>\$100,000</b> per year for worldwide emergency services and urgent care. Contact the plan for details.</p> |
|                                                             | Urgent care                                            | <b>\$0</b>                          | <p>Urgently needed services are not emergency care. You do not need prior authorization and you do not have to be in-network.</p> <p>In addition to the Medicare-covered urgent care services, this plan offers urgently needed services when traveling outside of the United States and its territories for less than six months. Coverage is limited to <b>\$100,000</b> per year for worldwide</p>                                                                                                                |

| Health need or concern                                                 | Services you may need                                                                                    | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>You need emergency care (continued)</b>                             |                                                                                                          |                                     | emergency services and urgent care. Contact the plan for details.                                                                                                                                                                                                                                                                                                                                         |
| <b>You need medical tests</b>                                          | Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs) | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                        | Lab tests and diagnostic procedures, such as blood work                                                  | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                      |
| <b>You need hearing/auditory services (continued on the next page)</b> | Hearing screenings                                                                                       | <b>\$0</b>                          | In addition to the Medicare-covered hearing evaluation services, this plan covers one (1) supplemental routine hearing exam every year.<br><br>Prior authorization may be required.                                                                                                                                                                                                                       |
|                                                                        | Hearing aids                                                                                             | <b>\$0</b>                          | This plan offers up to <b>\$3,000</b> toward the purchase of one (1) pair of supplemental prescribed hearing aid(s) or up to <b>\$300</b> towards the purchase of one (1) pair of over-the-counter hearing aid(s) and one (1) supplemental hearing aid fitting/evaluation every year.<br><br>This benefit is covered when you have full Medicaid eligibility.<br><br>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 hearing/auditory services (continued)    |                                       |                                     | Additional services may be covered in accordance with your Medicaid benefits and guidelines.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| You need dental care (continued on the next page) | Dental check-ups and preventive care  | <b>\$0</b>                          | <p>In addition to the Medicare-covered dental services, this plan offers up to <b>\$6,000</b> for covered supplemental preventive and comprehensive dental services every year. Any amount not used at the end of the calendar year will expire.</p> <p>You can use our coverage for these supplemental services: 2 oral exams, 2 cleanings, 2 fluoride treatments, and 2 dental X-rays every year. Please refer to the <i>Evidence of Coverage</i> for a full list of the dental benefits, prior authorizations, limitations, and exclusions.</p> <p>TennCare's dental health plan is DentaQuest. DentaQuest manages the dental benefits for all TennCare members. To find a DentaQuest dentist, go to <a href="http://www.dentaquest.com/state-plans/regions/tennessee/">http://www.dentaquest.com/state-plans/regions/tennessee/</a>. Then click Find a Dentist. Or you can call them at 1-855-418-1622.</p> |
|                                                   | Restorative and emergency dental care | <b>\$0</b>                          | In addition to the Medicare-covered dental services, this plan offers up to <b>\$6,000</b> for covered supplemental preventive and comprehensive dental services every year. Any amount not                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| 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 (continued)               |                           |                                     | <p>used at the end of the calendar year will expire.</p> <p>You can use our coverage for these supplemental services: fillings and repairs, root canals (endodontics), dental crowns (caps), bridges, and dentures. Please note that dental crown services require prior authorization. Please refer to the <i>Evidence of Coverage</i> for a full list of the dental benefits, prior authorizations, limitations, and exclusions.</p> <p>TennCare's dental health plan is DentaQuest. DentaQuest manages the dental benefits for all TennCare members. To find a DentaQuest dentist, go to <a href="http://www.dentaquest.com/state-plans/regions/tennessee/">http://www.dentaquest.com/state-plans/regions/tennessee/</a>. Then click Find a Dentist. Or you can call them at 1-855-418-1622.</p> |
| You need eye care (continued on the next page) | Eye Exams                 | \$0                                 | In addition to the Medicare-covered exam to treat an eye condition, this plan covers one (1) routine eye exam every year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                | Glasses or contact lenses | \$0                                 | In addition to Medicare-covered eye wear, this plan covers up to <b>\$650</b> for supplemental eyeglasses or contact lenses every year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Health need or concern                                                  | Services you may need                                                                                 | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>You need eye care (continued)</b>                                    | Other vision care                                                                                     | <b>\$0</b>                          | Please refer to your <i>Evidence of Coverage</i> for details.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>You need behavioral health services (continued on the next page)</b> | Behavioral Health Care (Mental health services)                                                       | <b>\$0</b>                          | <p>You do not need to see your PCP before getting Behavioral Health services. But, you will need to get your care from someone who is in our network. If you're getting care now, ask your provider if they take Wellpoint. A Community Mental Health Agency (CMHA) is one place you can go for mental health or substance use disorder services. Most CMHAs take TennCare.</p> <p>If you need help finding, or have questions about, mental health and substance use disorder services, call us at 1-833-731-2153 (TRS 711). It's a free call.</p> <p>Prior authorization may be required. Services may need to be ordered by a treating Physician.</p> <p>Please refer to your <i>Evidence of Coverage</i> for details.</p> |
|                                                                         | Inpatient and outpatient care and community-based services for people who need Mental Health Services | <b>\$0</b>                          | <p>You do not need to see your PCP before getting Behavioral Health services. But, you will need to get your care from someone who is in our network. If you're getting care now, ask your provider if they take Wellpoint. A Community Mental Health Agency (CMHA) is one place you can go for mental health or</p>                                                                                                                                                                                                                                                                                                                                                                                                          |

| Health need or concern                                        | Services you may need | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------|-----------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>You need behavioral health services (continued)</b></p> |                       |                                     | <p>substance use disorder services. Most CMHAs take TennCare.</p> <p>If you need help finding, or have questions about, mental health and substance use disorder services, call us at 1-833-731-2153 (TRS 711). It's a free call.</p> <p>Our plan has a lifetime limit of 190 days for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay.</p> <p>We pay for mental health care services that require a hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>Prior authorization may be required. Please contact your care coordinator to get information on how to access these services. Services may need to be ordered by a treating Physician. Please refer to your <i>Evidence of Coverage</i> for more information.</p> |

| Health need or concern                                                                         | Services you may need           | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>You need substance use disorder services</b>                                                | Substance use disorder services | <b>\$0</b>                          | <p>You do not need to see your PCP before getting Behavioral Health services. But, you will need to get your care from someone who is in our network. If you're getting care now, ask your provider if they take Wellpoint. A Community Mental Health Agency (CMHA) is one place you can go for mental health or substance use disorder services. Most CMHAs take TennCare.</p> <p>If you need help finding, or have questions about, mental health and substance use disorder services, call us at 1-833-731-2153 (TRS 711). It's a free call.</p> <p>Prior authorization may be required. Services may need to be ordered by a treating Physician.</p> <p>Please see your <i>Evidence of Coverage</i> for more information.</p> |
| <b>You need a place to live with people available to help you (continued on the next page)</b> | Skilled nursing care            | <b>\$0</b>                          | <p>This plan covers up to 100 days in a Skilled Nursing Facility (SNF).</p> <p>Prior authorization may be required.</p> <p>Additional services may be covered in accordance with your Medicaid benefits and guidelines.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                | Nursing home care               | <b>\$0</b>                          | 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 a place to live with people available to help you (continued) |                                                                                                     |                                     | Please refer to your <i>Evidence of Coverage</i> for details.                                                                                                                                                                                                                                                           |
|                                                                        | Adult Foster Care and Group Adult Foster Care                                                       | \$0                                 | Prior authorization may be required. Please refer to your <i>Evidence of Coverage</i> for details.                                                                                                                                                                                                                      |
| You need therapy after a stroke or accident                            | Occupational, physical, or speech therapy                                                           | \$0                                 | Prior authorization may be required.                                                                                                                                                                                                                                                                                    |
| You need help getting to health services (continued on the next page)  | Emergency transportation                                                                            | \$0                                 | In emergency situations this plan includes ground (ambulance) and air (airplane and helicopter) transportation. The transportation will take you to the nearest place that can give you care. Prior authorization may be required.<br><br>Prior authorization required for non-emergency ambulance transport services.  |
|                                                                        | Transportation to medical appointments and services (Non-Emergency transportation services or NEMT) | \$0                                 | This plan offers <b>unlimited</b> one-way routine health related transportation every year.<br><br>Trips are limited to 60 miles.<br><br>Routine transportation coverage is limited to plan-approved locations (within the local service area) provided by contracted transportation vendors in our plan. If you need a |

| 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 to health services (continued)                           |                                  |                                     | ride, call us at least 48 hours ahead of time (excluding weekends).<br><br>Additional services may be covered in accordance with your Medicaid benefits and guidelines.                                                                                                                                                                                                                       |
| You need drugs to treat your illness or condition (continued on the next page) | Medicare Part B 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.<br><br>Read the <i>Evidence of Coverage</i> for more information on these drugs.<br><br>Prior authorization may be required.                                                                                                                     |
|                                                                                | Medicare Part D drugs            |                                     | <b>Part D Drug Deductible:</b><br><b>If you receive Extra Help</b> , this payment stage does not apply to you.<br><b>If you do not qualify for Extra Help</b> , the deductible is <b>\$615.00</b> per year for Part D prescription drugs. Drugs listed on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty Tier are included in the Part D deductible. |
|                                                                                | <b>Tier 1: Preferred Generic</b> |                                     |                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                | Standard retail one-month supply | \$0.00                              |                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                | Mail order three-month supply    | \$0.00                              |                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                | <b>Tier 2: Generic</b>           |                                     |                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                | Standard retail one-month supply | \$0.00 - \$12.65<br>OR 25%*         | There may be limitations on the types of drugs covered. Refer to Wellpoint Full Dual Advantage 2 (HMO D-SNP)'s <i>List of Covered Drugs (Drug List)</i> for more information.                                                                                                                                                                                                                 |
|                                                                                | Mail order three-month supply    | \$0.00 - \$12.65<br>OR 25%*         |                                                                                                                                                                                                                                                                                                                                                                                               |

**If you have questions**, please call Wellpoint Full Dual Advantage 2 (HMO D-SNP) at **1-844-615-5445** (TTY 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. For more information, visit [shop.wellpoint.com/medicare](https://shop.wellpoint.com/medicare).

| 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) | <b>Tier 3: Preferred Brand</b>    |                                     |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | Standard retail one-month supply  | <b>\$0.00 - \$12.65<br/>OR 25%*</b> | Once you or others on your behalf pay <b>\$2,100</b> you've reached the catastrophic coverage stage and you pay <b>\$0</b> for all your Medicare drugs. Read the <i>Evidence of Coverage</i> for more information on this stage.                                                                                                                                   |
|                                                               | Mail order three-month supply     | <b>\$0.00 - \$12.65<br/>OR 25%*</b> |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | <b>Tier 4: Non-Preferred Drug</b> |                                     | Extended day supplies are available through retail and/or mail order.                                                                                                                                                                                                                                                                                              |
|                                                               | Standard retail one-month supply  | <b>\$0.00 - \$12.65<br/>OR 25%*</b> | <b>Important message about what you pay for vaccines and insulin:</b> This plan covers most part D vaccines at no cost to you. If you receive Extra Help, you pay <b>\$0.00-\$12.65</b> for a one-month supply of any covered insulin. If you do not qualify for Extra Help, you will not pay more than <b>\$35</b> for a one-month supply of any covered insulin. |
|                                                               | Mail order three-month supply     | <b>\$0.00 - \$12.65<br/>OR 25%*</b> |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | <b>Tier 5: Specialty Tier</b>     |                                     |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | Standard retail one-month supply  | <b>\$0.00 - \$12.65<br/>OR 25%*</b> | * If you receive Extra Help, the amount you pay is determined by your Extra Help low-income subsidy (LIS) coverage and whether you use a generic or brand drug. Please refer to your LIS Rider for your specific copayment amount. If you do                                                                                                                       |
|                                                               | Mail order three-month supply     | <b>Not available</b>                |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | <b>Tier 6: Select Care Drugs</b>  |                                     |                                                                                                                                                                                                                                                                                                                                                                    |
|                                                               | Standard retail one-month supply  | <b>\$0.00</b>                       |                                                                                                                                                                                                                                                                                                                                                                    |

| 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)                          | Mail order three-month supply   | <b>\$0.00</b><br><br>Copays for drugs may vary based on the level of Extra Help you get. Please contact the plan for more details. | not qualify for Extra Help, you pay the coinsurance.                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                        | Over-the-counter (OTC) drugs    | <b>\$0</b>                                                                                                                         | There may be limitations on the types of drugs covered. Please refer to Wellpoint Full Dual Advantage 2 (HMO D-SNP)'s <i>List of Covered Drugs (Drug List or Formulary)</i> for more information.<br><br>This plan offers a supplemental Over-the-Counter (OTC) benefit through a combined monthly spending allowance. Please refer to the <b>Everyday Options Allowance</b> benefit later in this document for more information. |
| You need help getting better or have special health needs (continued on the next page) | Rehabilitation services         | <b>\$0</b>                                                                                                                         | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                        | Medical equipment for home care | <b>\$0</b>                                                                                                                         | 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)                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>You need help getting better or have special health needs (continued)</b>                                                                                                                                       | Dialysis services                  | <b>\$0</b>                          |                                                                                                                                                                                                                                                                            |
| <b>You need foot care</b>                                                                                                                                                                                          | Podiatry services                  | <b>\$0</b>                          | In addition to the Medicare-covered podiatry services, this plan covers <b>unlimited</b> supplemental foot care visits every year.<br><br>Prior authorization may be required.                                                                                             |
|                                                                                                                                                                                                                    | Orthotic services                  | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                       |
| <b>You need durable medical equipment (DME) Note:</b><br>This isn't a complete list of covered DME. For a complete list, contact Member Services or refer to <b>Chapter 4</b> of the <i>Evidence of Coverage</i> . | Wheelchairs, crutches, and walkers | <b>\$0</b>                          | Wellpoint Full Dual Advantage 2 (HMO D-SNP) provides coverage for wheelchairs, crutches and walkers, as well as a wide range of other DME items. DME coverage is based on medical necessity and has no maximum benefit limits.<br><br>Prior authorization may be required. |
|                                                                                                                                                                                                                    | Nebulizers                         | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                    | Oxygen equipment and supplies      | <b>\$0</b>                          | 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                                 | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                           | Home services, such as cleaning or housekeeping, or home modifications such as grab bars | \$0                                 | <p>For home modifications such as grab bars: This plan offers a supplemental Home and Bathroom safety devices benefit through a combined monthly spending allowance. Please refer to the <b>Everyday Options Allowance</b> benefit later in this document for more information.</p> <p>For in-home services: please contact your care coordinator at the phone number listed on the bottom of this page to get information on how to access these services.</p> <p>Additional services may be covered in accordance with your Medicaid benefits and guidelines. Contact TennCare at 1-855-259-0701, 8:00am - 4:30pm CST.</p> <p>Prior authorization may be required.</p> |
|                                                           | Adult day health, Community Based Adult Services (CBAS), or other support services       | \$0                                 | For Adult day health, and Community Based Adult Services (CBAS): please contact your care coordinator to get information on how to access these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| 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)         |                                                                                                       |                                     | For other support services: please refer to your <i>Evidence of Coverage</i> for details.<br><br>Prior authorization may be required.                                                 |
|                                                  | Day habilitation services                                                                             | \$0                                 |                                                                                                                                                                                       |
|                                                  | Services to help you live on your own (home health care services or personal care attendant services) | \$0                                 |                                                                                                                                                                                       |
| Additional services (continued on the next page) | Chiropractic services                                                                                 | \$0                                 | In addition to the Medicare-covered chiropractic services, this plan covers <b>unlimited</b> supplemental chiropractor visits every year.<br><br>Prior authorization may be required. |
|                                                  | Diabetes supplies and services                                                                        | \$0                                 |                                                                                                                                                                                       |
|                                                  | Donor organ/tissue procurement services                                                               | \$0                                 |                                                                                                                                                                                       |
|                                                  | Organ and tissue transplant services                                                                  | \$0                                 |                                                                                                                                                                                       |
|                                                  | Private duty nursing services                                                                         | \$0                                 |                                                                                                                                                                                       |

| Health need or concern                 | Services you may need                | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------|--------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional services (continued)</b> | Prosthetic services                  | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                        | Radiation therapy                    | <b>\$0</b>                          | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                        | Reconstructive breast surgery        | <b>\$0</b>                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | Services to help manage your disease | <b>\$0</b>                          | Please refer to your <i>Evidence of Coverage</i> for details.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                        | 24/7 NurseLine                       | <b>\$0</b>                          | 24-hour access to a nurse helpline, 7 days a week, 365 days a year: <b>1-855-658-9249</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                        | Everyday Options Allowance           | <b>\$0</b>                          | <p>This benefit provides a combined monthly spending allowance of <b>\$203 each month</b> on your Benefits Mastercard® Prepaid Card for assistive devices, healthy foods*, over-the-counter (OTC) health and wellness products, and utilities*.</p> <p>You have the flexibility to choose how you want to spend your allowance on any of the following benefits:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Assistive Devices:</b> ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more.</li> <li><input type="checkbox"/> <b>Healthy Foods*:</b> Food items like fresh meats, fruits, and vegetables.</li> </ul> |

| Health need or concern          | Services you may need        | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------|------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Additional services (continued) |                              |                                     | <p>❑ <b>OTC:</b> Health and wellness products like vitamins, first aid supplies, pain-relievers, and more.</p> <p>❑ <b>Utilities*:</b> Use toward the payment of natural/propane gas, electric, water, cable, internet, or cell phone services. Unused amounts expire at the end of each month.</p> <p>* The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's <i>Evidence of Coverage</i>.</p> |
|                                 | Healthy Meals-Post Discharge | <b>\$0</b>                          | This plan offers up to 2 meals a day for 21 days following your discharge from the hospital or skilled nursing facility (SNF).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                 | LiveHealth Online            | <b>\$0</b>                          | Lets you talk to a board-certified doctor, or licensed psychiatrist, psychologist or therapist, by live, two-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| Health need or concern                 | Services you may need                     | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------|-------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional services (continued)</b> |                                           |                                     | <p>way video on a computer, smartphone or tablet.</p> <p>LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.</p>                                                                                                                                                                                       |
|                                        | Medicare Community Resource Support       | <b>\$0</b>                          | <p>We assist you right over the phone by providing you with health-related information and by connecting you to local community-based services and support programs. We'll help you coordinate these services based on your unique needs.</p> <p>For more details, call Member Services at the number listed on the bottom of the page and ask for the Medicare Community Resource Support team.</p> |
|                                        | Personal Emergency Response System (PERS) | <b>\$0</b>                          | Includes the monitoring device and monitoring service. To start and install services, give us a call. We can help you. For more details, please call the Member Services phone number listed at the bottom of this page.                                                                                                                                                                             |
|                                        | SilverSneakers*® Fitness program          | <b>\$0</b>                          | When you become our member, you can sign up for SilverSneakers. It's included in our plan. To learn more details, go to <b><a href="https://silversneakers.com">silversneakers.com</a></b> or call SilverSneakers at 1-855-741-4985 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET.                                                                                                          |

**If you have questions**, please call Wellpoint Full Dual Advantage 2 (HMO D-SNP) at **1-844-615-5445** (TTY 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. For more information, visit **[shop.wellpoint.com/medicare](https://shop.wellpoint.com/medicare)**.

| Health need or concern          | Services you may need | Your costs for in-network providers | Limitations, exceptions, & benefit information (rules about benefits)                                                                                                                    |
|---------------------------------|-----------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Additional services (continued) |                       |                                     | * SilverSneakers is a registered trademark of Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan. |

The above summary of benefits is provided for informational purposes only and isn't a complete list of benefits. For a complete list and more information about your benefits, you can read the Wellpoint Full Dual Advantage 2 (HMO D-SNP)'s *Evidence of Coverage*. If you don't have an *Evidence of Coverage*, call Wellpoint Full Dual Advantage 2 (HMO D-SNP) Member Services at the number at the bottom of this page to get one. If you have questions, you can also call Member Services or visit <https://shop.wellpoint.com/medicare>.

## D. Benefits covered outside of Wellpoint Full Dual Advantage 2 (HMO D-SNP)

There are some services that you can get that aren't covered by Wellpoint Full Dual Advantage 2 (HMO D-SNP) but are covered by Medicare, TennCare, or a State or county agency. This isn't a complete list. Call Member Services at the number at the bottom of this page to find out about these services.

In addition to the Medicare services described in the "Additional benefits" section on the previous pages, Wellpoint provides the following Medicaid benefits based on the level of your Medicaid coverage. For eligibility rules and additional information about these services, please visit .

There may be instances when the Medicaid limit is greater than the Medicare limit. In those instances where the Medicare limit has been exhausted, the Plan will cover the difference for those eligible recipients.

| Other services covered by Medicare, TennCare, or a State Agency                                                                                                                                                                   | Your costs |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Community health services                                                                                                                                                                                                         | \$0        |
| Dental services                                                                                                                                                                                                                   | \$0        |
| Durable medical equipment                                                                                                                                                                                                         | \$0        |
| Early and periodic screening, diagnosis, and treatment (EPSDT) services for TennCare Medicaid-eligible children under age 21; preventive, diagnostic, and treatment services for TennCare Standard-eligible children under age 21 | \$0        |
| Emergency air and group transportation services                                                                                                                                                                                   | \$0        |
| Home health care                                                                                                                                                                                                                  | \$0        |
| Hospice care - certain hospice care services covered outside of Wellpoint Full Dual Advantage 2 (HMO D-SNP)                                                                                                                       | \$0        |
| Inpatient and outpatient substance abuse benefits                                                                                                                                                                                 | \$0        |
| Inpatient hospital services                                                                                                                                                                                                       | \$0        |
| Lab and x-ray services                                                                                                                                                                                                            | \$0        |

| Other services covered by Medicare, TennCare, or a State Agency                  | Your costs |
|----------------------------------------------------------------------------------|------------|
| Medical supplies                                                                 | \$0        |
| Mental health case management                                                    | \$0        |
| Mental health crisis services                                                    | \$0        |
| Non-emergency transportation services                                            | \$0        |
| Occupational therapy                                                             | \$0        |
| Organ and tissue transplant services and donor organ/tissue procurement services | \$0        |
| Outpatient hospital services                                                     | \$0        |
| Outpatient mental health services                                                | \$0        |
| Pharmacy services                                                                | \$0        |
| Physical therapy services                                                        | \$0        |
| Physician services                                                               | \$0        |
| Private duty nursing services                                                    | \$0        |
| Psychiatric inpatient facility services                                          | \$0        |
| Psychosocial rehabilitation                                                      | \$0        |
| Reconstructive breast surgery                                                    | \$0        |
| Renal dialysis clinic services                                                   | \$0        |
| Rest home room and board                                                         | \$0        |
| Speech therapy services                                                          | \$0        |
| Targeted case management                                                         | \$0        |
| Vision services (for children under age 21)                                      | \$0        |

**If you have questions**, please call Wellpoint Full Dual Advantage 2 (HMO D-SNP) at **1-844-615-5445** (TTY 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. For more information, visit [shop.wellpoint.com/medicare](https://shop.wellpoint.com/medicare).

## E. Services that Wellpoint Full Dual Advantage 2 (HMO D-SNP), Medicare, and TennCare don't cover

This isn't a complete list. Call Member Services at the number listed at the bottom of this page to find out about other excluded services.

| Services that Wellpoint Full Dual Advantage 2 (HMO D-SNP), Medicare, and TennCare do not cover                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Services considered not "reasonable and medically necessary", according to Medicare and TennCare standards                                                     |
| Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.         |
| Any medical or behavioral health (mental health, alcohol or substance use disorder) treatment outside of the United States.                                    |
| Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it                                                                |
| A private room in a hospital, except when medically necessary                                                                                                  |
| Personal items in your room at a hospital or a nursing facility, such as a telephone or television                                                             |
| Full-time nursing care in your home                                                                                                                            |
| Fees charged by your immediate relatives or members of your household                                                                                          |
| Elective or voluntary enhancement procedures or services                                                                                                       |
| Cosmetic surgery or other cosmetic work                                                                                                                        |
| Routine foot care, except as described in Podiatry services                                                                                                    |
| Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease |
| Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease                                              |
| Radial keratotomy, LASIK surgery, and other low-vision aids                                                                                                    |
| Reversal of sterilization procedures and non-prescription contraceptive supplies                                                                               |
| Naturopath services (the use of natural or alternative treatments)                                                                                             |

## F. Your rights as a member of the plan

As a member of Wellpoint Full Dual Advantage 2 (HMO D-SNP), 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'll tell you about your rights at least once a year. For more information on your rights, please read the *Evidence of Coverage*. Your rights include, but aren't 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, public assistance, or other groups protected by the civil rights laws. You have a right to report or file a written complaint if you think you've been treated differently. Being treated differently means you've been discriminated against. If you complain, you have the right to keep getting care without fear of bad treatment from Wellpoint Full Dual Advantage 2 (HMO D-SNP), providers, or TennCare. To file a complaint or learn more about your rights visit: [www.tn.gov/tenncare/members-applicants/civil-rights-compliance](http://www.tn.gov/tenncare/members-applicants/civil-rights-compliance)
  - Get information in other languages and formats (for example, large print, accessible electronic documents, 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 and care coordinator

- **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're 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. Wellpoint Full Dual Advantage 2 (HMO D-SNP) 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 doesn't 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
- Have privacy during treatment
- **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 TennCare at 1-800-878-3192 or 1-866-771-7043 TTY. The Wellpoint Full Dual Advantage 2 (HMO D-SNP) website <https://shop.wellpoint.com/medicare> has complaint forms and instructions available online.
  - Ask for an Independent Medical Review (IMR) of TennCare services or items that are medical in nature.
  - Appeal certain decisions made by State Department of Managed Health Care 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 *Evidence of Coverage*. If you have questions, you can also call Wellpoint Full Dual Advantage 2 (HMO D-SNP) Member Services at the number listed at the bottom of this page.

You can also call TennCare Connect for people who have Medicare and TennCare at 1-800-259-0701.

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

If you have a complaint or think Wellpoint Full Dual Advantage 2 (HMO D-SNP) should cover something we denied, call Member Services at **1-833-713-1074** (TTY: **711**) or 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 *Evidence of Coverage*. You can also call Wellpoint Full Dual Advantage 2 (HMO D-SNP) Member Services at **1-833-713-1074** (TTY: **711**).

## 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 Wellpoint Full Dual Advantage 2 (HMO D-SNP) Member Services. The phone number is listed in the footer of each page of this document.
- ❑ 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.
- ❑ TennCare's Office of Program Integrity (OPI), call the toll-free hotline 1-800-433-3982 or TTY users may call 1-877-779-3103.

**If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call Wellpoint Full Dual Advantage 2 (HMO D-SNP) Member Services:**

### **CALL: 1-833-713-1074**

Calls to this number are free.

8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Member Services also has free language interpreter services available for non-English speakers.

### **TTY: 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. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

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### **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 Wellpoint Full Dual Advantage 2 (HMO D-SNP)'s 24/7 NurseLine at **1-866-805-4589** (TTY: **711**). A nurse will listen to your problem and tell you how to get care.
  - ☐ Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
  - ☐ Wellpoint Full Dual Advantage 2 (HMO D-SNP) also has free language interpreter service available for non-English speakers.
  - ☐ TTY: **711**. Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
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## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-844-615-5445 (TTY: 711)** or speak to your provider. Hours of operation are 8 a.m. to 8 p.m. local time, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

**Spanish** – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente o hable con su proveedor. El horario de atención es de 8 a.m. a 8 p.m. hora local, los siete días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.o de octubre hasta el 31 de marzo, y de lunes a viernes (excepto los días feriados) desde el 1.o de abril hasta el 30 de septiembre.

**Amharic** – ያስተውሉ:- አማርኛ የሚናገሩ ከሆነ፣ነጻ የቋንቋ እርዳታ አገልግሎቶች ለእርስዎ ይገኛሉ። መረጃን በተደራሽ ቅርጾች ለማቅረብ አግባብ የሆኑ ረዳት መርጃዎች እና አገልግሎቶችም በነጻ ይገኛሉ። ከላይ በተጠቀሰው ሰልክ ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። የስራ ሰዓቶች ከጠዋቱ 8 ሰዓት እስከ ከሰዓት 8 ሰዓት የአካባቢ ሰዓት፣ በሳምንት ሰዓት ቀናት (ከምስጋና እና የገና በዓላት በስተቀር) ከአክቶበር 1 እስከ ማርች 31፣ እና ከሰኞ እስከ አርብ (ከበዓላት በስተቀር) ከሚያዝያ 1 እስከ ሴፕቴምበር 30 ናቸው።

**Arabic** - تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجاناً. اتصل برقم الهاتف المذكور أعلاه أو تحدث إلى مقدم الخدمة الخاص بك. ساعات العمل من الساعة 8 صباحاً حتى الساعة 8 مساءً على مدار الأسبوع (ما عدا أيام عيد الشكر وعيد الميلاد) بدايةً من 1 أكتوبر حتى 31 مارس، ومن الاثنين حتى الجمعة (ما عدا أيام العطلات) من 1 أبريل حتى 30 سبتمبر.

**Bengali** – মনোযোগ দনি: যদিআপনিবাংলা ভাষায় কথা বলেন, তবে আপনার জন্য বনিমূল্যে ভাষা সহায়তা পরষিবো উপলব্ধ রয়েছে। তথ্য সহজলভ্য ফরম্যাটে পাওয়ার জন্য প্রয়োজনীয় সহায়ক সরঞ্জাম ও পরষিবোও বনিমূল্যে প্রদান করা হয়। উপরে উল্লেখিতি ফোন নম্বরে ফোন করুন অথবা আপনার পরষিবো সরবরাহকারীর সাথে কথা বলুন। কার্যক্রমের সময় সকাল ৪ টা থেকে রাত ৪ টা পর্যন্ত (স্থানীয় সময় অনুযায়ী), সপ্তাহে সাত দিন (শুধুমাত্র থ্যাংকসগভিং ও বড়দিন ছাড়া) অক্টোবর 1 থেকে মার্চ 31 পর্যন্ত এবং এপ্রিল 1 থেকে সেপ্টেম্বর 30 পর্যন্ত সোমবার থেকে শুক্রবার (ছুটির দিন ছাড়া) কার্যক্রম পরিচালিত হয়।

**Chinese Simplified** – 注意：如果您说简体中文，我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，以可访问的格式提供信息。

请拨打上面列出的电话号码或与您的提供者交谈。营业时间：10月1日至3月31日，每周七天（感恩节和圣诞节除外），4月1日至9月30日，周一至周五（节假日除外），当地时间上午8时至晚上8时。

**Chinese Traditional** – 注意：如果您說繁體中文，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼或與您的提供者交談。營業時間：10月1日至3月31日，每週七天（感恩節和耶誕節除外），4月1日至9月30日，週一至週五（節假日除外），當地時間上午8時至晚上8時。

**Farsi** - توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان قابل ارائه به شما است. وسایل و خدمات کمکی مناسب برای ارائه اطلاعات در قالب های مناسب معلولان نیز به صورت رایگان قابل ارائه است. با شماره تلفن بالا تماس بگیرید یا با ارائه دهنده تماس صحبت کنید. ساعات کاری: از 8 صبح تا 8 شب به وقت محلی از 1 اکتبر تا 31 مارس (به جز کریسمس و روز شکرگزاری) در هفت روز هفته و از 1 آوریل تا 30 سپتامبر از دوشنبه تا جمعه (به جز تعطیلات).

**French** – ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus ou appelez votre prestataire. Les heures d'ouverture sont de 8 a.m à 8 p.m., heure locale, sept jours sur sept (sauf Thanksgiving et Noël) du 1er octobre au 31 mars, et du lundi au vendredi (sauf jours fériés) du 1er avril au 30 septembre.

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die oben aufgeführte Telefonnummer an oder wenden Sie sich an Ihren Anbieter. Die Geschäftszeiten sind 8 Uhr bis 20 Uhr lokaler Zeit an sieben Tagen in der Woche (außer Thanksgiving und Weihnachten) vom 1. Oktober bis zum 31. März, und Montag bis Freitag (außer an Feiertagen) vom 1. April bis zum 30. September.

**Gujarati** – ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે વનિ મૂલ્યે ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુવલ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ વનિ મૂલ્યે ઉપલબ્ધ છે. ઉપર દર્શાવેલ ફોન નંબર પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. કામકાજના ક્વાકો સ્થાનકિ સમય મુજબ સવારે 8 વાગ્યાથી સાંજના 8 વાગ્યા સુધી, ઓક્ટોબર 1 થી માર્ચ 31 સુધી અઠવાડિયાના સાતેય દવિસ (થેક્સગવિગિ અને ક્રસિમસ સવાિય) અને સોમવારથી શુક્રવાર (રજાઓ સવાિય) એપ્રિલ 1 થી સપ્ટેમ્બર 30 સુધી છે.

**Hindi** – ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नशिल्क भाषा सहायता सेवाएं उपलब्ध हैं। पहुँच योग्य प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नशिल्क उपलब्ध हैं। ऊपर दिए गए फोन नंबर पर कॉल करें या अपने प्रदाता से बात करें। कामकाज के घंटे, 1 अक्टूबर से 31 मार्च तक सप्ताह के सातों दिनों (थैंक्सगिविंग और क्रिसमस को छोड़कर), और 1 अप्रैल से 30 सितंबर तक

सोमवार से शुक्रवार (छुट्टियों को छोड़कर), स्थानीय समय अनुसार सुबह 8 बजे से रात 8 बजे तक हैं।

**Japanese** – 注意：日本語を話せる方向けに、無料の言語支援サービスをご提供しています。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらでも無料でご利用いただけます。必要な情報取得にお役立てください。上記の電話番号にお電話いただくか、プロバイダーにお問い合わせください。営業時間は、10月1日から3月31日までは現地時間午前8時から午後8時まで週7日（感謝祭とクリスマスを除く）、および4月1日から9月30日まで（祝日を除く）は月曜日から金曜日までです。

**Korean** – 주의: 한국어를 구사하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 위의 전화 번호로 전화하시거나 담당 의료 제공자에게 문의해 주십시오. 운영 시간은 현지 시간 오전 8시부터 오후 8시까지이며 10월 1일부터 3월 31일까지는 주 7일(추수 감사절과 성탄절은 제외) 내내, 4월 1일부터 9월 30일까지는 월요일부터 금요일까지(휴일은 제외)입니다.

**Laotian** – ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ນອກຈາກນີ້ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທລະສັບທີ່ລະບຸໄວ້ຂ້າງເທິງຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. ເວລາຮັດວຽກແມ່ນ 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ ຕາມເວລາໃນທ້ອງຖິ່ນ, ເຈັດມື້ຕໍ່ອາທິດ (ຍົກເວັ້ນວັນຂອບໃຈພະເຈົ້າ ແລະ ວັນຄຣິດສະມາດ) ຕັ້ງແຕ່ວັນທີ 1 ຕຸລາ ຫາ ວັນທີ 31 ມີນາ, ແລະ ວັນຈັນເຖິງວັນສຸກ (ຍົກເວັ້ນວັນພັກ) ຕັ້ງແຕ່ວັນທີ 1 ເມສາ ຫາ 30 ກັນຍາ

**Portuguese** – ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado ou fale com o seu fornecedor. Horário de expediente: das 8h às 20h, (hora local), sete dias por semana (exceto Dia de Ação de Graças e Natal) de 1 de outubro até 31 de março, e de segunda a sexta-feira (exceto feriados) de 1 de abril até 30 de setembro.

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона или обсудите этот вопрос с вашим поставщиком услуг. Часы работы: с 08:00 до 20:00 в любой день недели (кроме Дня благодарения и Рождества) с 1 октября по 31 марта и с понедельника по пятницу (кроме праздничных дней) с 1 апреля по 30 сентября.

**Serbian – ПАЗЊА:** Ако говорите српски, доступне су вам бесплатне услуге помоћи за ваш језик. Бесплатно су вам доступна и одговарајућа помагала и услуге у доступним форматима како бисте добили информације које су вам потребне. Позовите број телефона наведен изнад или поразговарајте са својим пружаоцем услуга. Радно време је од 8 до 20 часова по локалном времену, седам дана у недељи (осим Дана захвалности и Божића) од 1. октобра до 31. марта, односно од понедељка до петка (осим празника) од 1. априла до 30. септембра.

**Tagalog – PAUNAWA:** Kung nagsasalita ka Tagalog, mayroong available na mga libreng serbisyo sa tulong sa wika para sa iyo. Ang naaangkop na mga karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay available rin nang walang bayad. Tawagan ang numero ng telepono na nakalista sa itaas o makipag-usap sa iyong provider. Ang mga oras ng opisina ay 8 a.m. hanggang 8 p.m., lokal na oras, pitong araw sa isang linggo (maliban sa Thanksgiving at Pasko) mula Oktubre 1 hanggang Marso 31, at Lunes hanggang Biyernes (maliban sa mga holiday) mula Abril 1 hanggang Setyembre 30.

**Telugu – గమనిక:** మేీరు తేలుగులో మాట్లాడదలచుకుంటే కనుక, మేీకు ఉచిత భష సహాయ సేవలు అందుబాటులో ఉన్నయి. అందుబాటులో ఉన్న షర్మాట్లలో సమాచరణ్ని అందించడనికి తగిన సహాయక పరికరలు, సేవలు కూడ ఉచితంగ లభిన్తయి. వైన జబితలో తలీవిన ఫ్న్ నంబర్కు కల్ చేయండి లేద మేీ వోవైడర్తో మాట్లాడండి. పని వేళలు అక్టోబర్ 1 నుండి మార్చి 31 వరకు వరనికి ఏడు రేజులు (థంక్స్ గివింగ్, క్రిస్మస్ మినహ) వటు, ఏప్రిల్ 1 నుండి సెప్టెంబర్ 30 వరకు నోమవరం నుండి శుక్రవరం వరకు (సలమలు మినహ) న్ధనిక సమయం ఉదయం 8 గంటల నుండి రత్రి 8 గంటల వరకు.

**Vietnamese – CHÚ Ý:** Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên hoặc nói chuyện với nhà cung cấp của quý vị. Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ địa phương, bảy ngày một tuần (Trừ Lễ Tạ ơn và Giáng sinh) từ ngày 1 Tháng Mười đến 31 Tháng Ba, và Thứ Hai đến Thứ Sáu (trừ các ngày lễ), từ ngày 1 Tháng Tư đến 30 Tháng Chín.

## IMPORTANT INFORMATION: 2025 Medicare Star Ratings

Official U.S.  
Government  
Medicare  
Information



Wellpoint - H5828

**For 2025, Wellpoint - H5828 received the following Star Ratings from Medicare:**

**Overall Star Rating:** ★★★★★

**Health Services Rating:** ★★★★★

**Drug Services Rating:** ★★★★★

**Every year, Medicare evaluates plans based on a 5-star rating system.**

### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- ☐ Feedback from members about the plan's service and care
- ☐ The number of members who left or stayed with the plan
- ☐ The number of complaints Medicare got about the plan
- ☐ Data from doctors and hospitals that work with the plan

**The number of stars show how well a plan performs.**

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

### Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

### Questions about this plan?

Contact Wellpoint 7 days a week from 8 a.m. to 8 p.m., (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30 at 1-877-470-4131 (toll-free) or 711 (TTY).

Current members please call 1-833-713-1074 (toll-free) or 711 (TTY).

Wellpoint Tennessee, Inc. is an HMO D-SNP plan with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in Wellpoint Tennessee, Inc. depends on contract renewal.

# 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 **1-844-615-5445** TTY: **711**, 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

## 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 <https://shop.wellpoint.com/medicare> or call **1-844-615-5445** to view a copy of the EOC.
- ☐ 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 medicines 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

- ☐ **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.
- ☐ 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, 2027.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.