2022
Summary of Benefits

Texas

Wellcare No Premium (HMO-POS)

H0174 | 012 | 001

Wellcare No Premium (HMO-POS)

H0174 | 012 | 004

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

This is a summary of drug and health services covered by Wellcare No Premium (HMO-POS) and Wellcare No Premium (HMO-POS) from January 1, 2022 to December 31, 2022.

This booklet will provide you with a summary of what we cover and the cost-sharing responsibilities. It does not list every service, limitation, or exclusion. A complete list of services can be found in the plan's Evidence of Coverage (EOC). You can find the Evidence of Coverage on our website at www.wellcare.com/medicare. Or, you may call us to ask for a copy at the phone number listed on the back cover.

Who can join?

To enroll in one of our plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

Our plans and service areas:
H0174012001 Wellcare No Premium (HMO-POS) includes these counties in Texas: Bastrop, Blanco, Burnet, Caldwell, Hays, Lee, Milam, Travis, and Williamson.

H0174012004 Wellcare No Premium (HMO-POS) includes these counties in Texas: Bexar, Comal, and Guadalupe.

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

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

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

Our plans also include prescription drug coverage and access to our large network of pharmacies. Our plans use a formulary. Our drug plans are designed specifically for Medicare beneficiaries and include a comprehensive selection of affordable generic and brand name drugs.

Which doctors, hospitals and pharmacies can I use? Wellcare No Premium (HMO-POS) and Wellcare No Premium (HMO-POS) have a network of doctors, hospitals, pharmacies, and other providers. You can save

money by using our preferred mail-order pharmacy and by using providers in the plan's network. With some plans if you use providers that are not in our network, your share of the costs for covered services may be higher.

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

For more information, please call us at 1-844-917-0175 (TTY users should call 711). Hours are Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. Visit us at www.wellcare.com/medicare.

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

Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Service Area	**Our plans and service areas:** **H0174012001 Wellcare No Premium (HMO-POS)** includes these counties in Texas: Bastrop, Blanco, Burnet, Caldwell, Hays, Lee, Milam, Travis, and Williamson. **H0174012004 Wellcare No Premium (HMO-POS)** includes these counties in Texas: Bexar, Comal, and Guadalupe.	
Monthly plan premium You must continue to pay your Medicare Part B premium.	$0	$0
Deductible	No deductible	No deductible
Maximum out-of-Pocket Responsibility (does not include prescription drugs)	$4,500 in-network annually $4,500 combined in and out-of-network annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.	$4,500 in-network annually $4,500 combined in and out-of-network annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.

Services with an asterisk (*) may require prior authorization.
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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Inpatient Hospital coverage	**In-Network** For each admission, you pay: • $250 copay per day for days 1 through 7 • $0 copay per day for days 8 through 90 ▪ * **Out-of-Network** Days 1-90: 35% coinsurance per stay. *	**In-Network** For each admission, you pay: • $225 copay per day for days 1 through 8 • $0 copay per day for days 9 through 90 ▪ * **Out-of-Network** Days 1-90: 35% coinsurance per stay. *
Outpatient Hospital coverage Outpatient hospital services	**In-Network** $250 copay per non-surgical service $295 copay per surgical service ▪ * **Out-of-Network** 35% coinsurance for surgical and non-surgical services *	**In-Network** $250 copay per non-surgical service $295 copay per surgical service ▪ * **Out-of-Network** 35% coinsurance for surgical and non-surgical services *

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Outpatient hospital observation services	**In-Network** $90 copay for outpatient observation services when you enter observation status through an emergency room. $295 copay for outpatient observation services when you enter observation status through an outpatient facility. ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $90 copay for outpatient observation services when you enter observation status through an emergency room. $295 copay for outpatient observation services when you enter observation status through an outpatient facility. ▪ * **Out-of-Network** 35% coinsurance *
Ambulatory surgical center (ASC)	**In-Network** $175 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $175 copay ▪ * **Out-of-Network** 35% coinsurance *
Doctor Visits Primary Care Providers	**In-Network** $0 copay **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay **Out-of-Network** 35% coinsurance *

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Specialists	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *
Preventive Care (e.g., Annual Wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular screenings, Cervical and vaginal cancer screening, Colorectal cancer screenings, Diabetes screenings, Hepatitis B Virus Screening, Prostate cancer screenings (PSA), Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots))	**In-Network** $0 copay **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay **Out-of-Network** 35% coinsurance*
Emergency care	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.

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	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	**Wellcare No Premium (HMO-POS) H0174, Plan 012, 004**
Worldwide emergency coverage	$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.	$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.
Urgently needed services	$30 copay Copay is waived if you are admitted to a hospital within 24 hours.	$30 copay Copay is waived if you are admitted to a hospital within 24 hours.
Worldwide urgent care coverage	$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.	$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Diagnostic Services/Labs/Imaging	COVID-19 testing and specified testing-related services at any location are $0.	COVID-19 testing and specified testing-related services at any location are $0.
Lab services	**In-Network** $0 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay ▪ * **Out-of-Network** 35% coinsurance *
Diagnostic tests and procedures	**In-Network** $0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. $0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. $30 copay for all other Medicare-covered diagnostic procedures and tests. ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. $0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. $30 copay for all other Medicare-covered diagnostic procedures and tests. ▪ * **Out-of-Network** 35% coinsurance *

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	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Outpatient X-rays	**In-Network** $0 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay ▪ * **Out-of-Network** 35% coinsurance *
Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** $0 copay for a DEXA scan. $0 copay for a Diagnostic Mammogram. $75 copay for diagnostic radiology services at all other locations. $250 copay for diagnostic radiology services received in an outpatient setting. ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay for a DEXA scan. $0 copay for a Diagnostic Mammogram. $75 copay for diagnostic radiology services at all other locations. $250 copay for diagnostic radiology services received in an outpatient setting. ▪ * **Out-of-Network** 35% coinsurance *
Therapeutic Radiology	**In-Network** 20% coinsurance ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** 20% coinsurance ▪ * **Out-of-Network** 35% coinsurance *

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	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Hearing services Hearing Exam Medicare Covered	**In-Network** $30 copay * **Out-of-Network** 35% coinsurance *	**In-Network** $30 copay * **Out-of-Network** 35% coinsurance *
Routine hearing exam	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year
Hearing Aids Hearing Aid Fitting/Evaluation(s)	**In-Network** $0 copay * **Out-of-Network** Not covered 1 fitting(s) / evaluation(s) every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 fitting(s) / evaluation(s) every year

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	**Wellcare No Premium (HMO-POS) H0174, Plan 012, 004**
Hearing aid allowance	Up to a $1,500 allowance for both ears combined every year for hearing aids.	Up to a $1,500 allowance for both ears combined every year for hearing aids.
All types	**In-Network** $0 copay * **Out-of-Network** Not covered Limited to 2 hearing aid(s) every year	**In-Network** $0 copay * **Out-of-Network** Not covered Limited to 2 hearing aid(s) every year
Additional Hearing Information	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Dental services		
Preventive services	**In-Network** $0 copay * **Out-of-Network** Not covered Cleanings 2 every year Dental x-rays 1 every 12 to 36 months Oral exams 2 every year	**In-Network** $0 copay * **Out-of-Network** Not covered Cleanings 2 every year Dental x-rays 1 every 12 to 36 months Oral exams 2 every year
Fluoride Treatment	**In-Network** $0 copay * **Out-of-Network** Not covered 1 every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 every year
Comprehensive services Medicare Covered	**In-Network** $30 copay for each Medicare-covered service. * **Out-of-Network** 35% coinsurance for each Medicare-covered service. *	**In-Network** $30 copay for each Medicare-covered service. * **Out-of-Network** 35% coinsurance for each Medicare-covered service. *

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Diagnostic Services	**In-Network** $0 copay * **Out-of-Network** Not covered 1 diagnostic service(s) every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 diagnostic service(s) every year
Restorative Services	**In-Network** $0 copay * **Out-of-Network** Not covered 1 restorative service(s) every 12 to 84 months	**In-Network** $0 copay * **Out-of-Network** Not covered 1 restorative service(s) every 12 to 84 months.
Endodontics/ Periodontics/ Extractions	**In-Network** $0 copay * **Out-of-Network** Not covered 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months 1 extraction(s) per tooth	**In-Network** $0 copay * **Out-of-Network** Not covered 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months 1 extraction(s) per tooth

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Non-routine services	**In-Network** $0 copay * **Out-of-Network** Not covered 1 non-routine service(s) every day to 60 months	**In-Network** $0 copay * **Out-of-Network** Not covered 1 non-routine service(s) every day to 60 months
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	**In-Network** $0 copay * **Out-of-Network** Not covered 1 Prosthodontic procedure every 12 to 84 months 1 Oral Maxillofacial procedure every 12 to 60 months or per lifetime 1 Other service every 6 to 60 months	**In-Network** $0 copay * **Out-of-Network** Not covered 1 Prosthodontic procedure every 12 to 84 months 1 Oral Maxillofacial procedure every 12 to 60 months or per lifetime 1 Other service every 6 to 60 months
Additional Dental Information	**What you should know:** This plan includes coverage of preventive and comprehensive services up to $3,000.	**What you should know:** This plan includes coverage of preventive and comprehensive services up to $3,000.

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	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Vision Services Eye Exam Medicare Covered	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) $30 copay (all other Medicare-covered eye exams) * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay (Medicare-covered diabetic retinopathy screening) $30 copay (all other Medicare-covered eye exams) * **Out-of-Network** 35% coinsurance *
Routine eye exam (Refraction)	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year	**In-Network** $0 copay * **Out-of-Network** Not covered 1 exam every year
Glaucoma screening	**In-Network** $0 copay for each Medicare-covered service. ▪ **Out-of-Network** 35% coinsurance for each Medicare-covered service. *	**In-Network** $0 copay for each Medicare-covered service. ▪ **Out-of-Network** 35% coinsurance for each Medicare-covered service. *
Eyewear Medicare Covered	**In-Network** $0 copay * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay * **Out-of-Network** 35% coinsurance *

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	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Routine eyewear Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames	**In-Network** $0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year * **Out-of-Network** Not covered	**In-Network** $0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year * **Out-of-Network** Not covered
Eyewear allowance	Up to a $100 combined allowance every year.	Up to a $100 combined allowance every year
Mental Health Services		
Inpatient visit	**In-Network** For each admission, you pay: • $250 copay per day for days 1 through 7 • $0 copay per day for days 8 through 90 ▪ * **Out-of-Network** Days 1-90: 35% coinsurance per stay. *	**In-Network** For each admission, you pay: • $225 copay per day for days 1 through 8 • $0 copay per day for days 9 through 90 ▪ * **Out-of-Network** Days 1-90: 35% coinsurance per stay. *

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	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Outpatient individual therapy visit	**In-Network** $25 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $25 copay ▪ * **Out-of-Network** 35% coinsurance *
Outpatient group therapy visit	**In-Network** $25 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $25 copay ▪ * **Out-of-Network** 35% coinsurance *
Skilled nursing facility (SNF)	**In-Network** For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $165 copay per day for days 21 through 100 ▪ * **Out-of-Network** Days 1-100: 35% coinsurance per benefit period. *	**In-Network** For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $165 copay per day for days 21 through 100 ▪ * **Out-of-Network** Days 1 - 100: 35% coinsurance per benefit period. *

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Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Therapy and Rehabilitation Services		
Physical Therapy	**In-Network** $35 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $35 copay ▪ * **Out-of-Network** 35% coinsurance *
Outpatient rehabilitation services provided by an occupational therapist	**In-Network** $35 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $35 copay ▪ * **Out-of-Network** 35% coinsurance *
Pulmonary rehabilitation services	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *

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Ambulance Ground Ambulance	**In-Network** $225 copay * **Out-of-Network** 35% coinsurance *	**In-Network** $225 copay * **Out-of-Network** 35% coinsurance *
Air Ambulance	**In-Network** $225 copay * **Out-of-Network** 35% coinsurance *	**In-Network** $225 copay * **Out-of-Network** 35% coinsurance *
Transportation Services	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered
Medicare Part B Drugs Chemotherapy drugs	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *

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Other Part B drugs	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *

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Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001		Wellcare No Premium (HMO-POS) H0174, Plan 012, 004	
Stage 1: Annual Prescription Deductible				
Deductible	This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.		This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.	
Stage 2: Initial Coverage (after you pay your deductible, if applicable)				
You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.				
Retail cost-sharing (30-day/90-day supply)				
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	$0 / $0 copay	$5 / $15 copay	$0 / $0 copay	$5 / $15 copay
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	$20 / $60 copay	$30 / $90 copay	$20 / $60 copay	$30 / $90 copay
Tier 4 (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	$75 / $225 copay	$85 / $255 copay	$75 / $225 copay	$85 / $255 copay

Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001		Wellcare No Premium (HMO-POS) H0174, Plan 012, 004	
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 5 (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available
Tier 6 (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay

Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001		Wellcare No Premium (HMO-POS) H0174, Plan 012, 004	
Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)				
Mail-order cost-sharing (30-day/90-day supply)				
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	$0 / $0 copay	$5 / $15 copay	$0 / $0 copay	$5 / $15 copay
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	$20 / $40 copay	$30 / $90 copay	$20 / $40 copay	$30 / $90 copay
Tier 4 (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	$75 / $150 copay	$85 / $255 copay	$75 / $150 copay	$85 / $255 copay
Tier 5 (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available

Prescription Drug Coverage	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001		Wellcare No Premium (HMO-POS) H0174, Plan 012, 004	
	Preferred	**Standard**	**Preferred**	**Standard**
Tier 6 (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay	$0 / $0 copay
Stage 3: Coverage Gap				
	After your total drug costs (including what our plan has paid and what you have paid) reach $4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap. During this stage, for Tier 1 and select drugs on Tier 6, you pay your copayment or coinsurance. Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.		After your total drug costs (including what our plan has paid and what you have paid) reach $4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap. During this stage, for Tier 1 and select drugs on Tier 6, you pay your copayment or coinsurance. Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.	
Stage 4: Catastrophic Coverage				
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% coinsurance, or • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% coinsurance, or • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay for all other drugs.	

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

Excluded Drugs:

This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil and Vardenafil on Tier 1 have a quantity limit of six pills every 30 days.

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

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Chiropractic Services Medicare-covered	**In-Network** $20 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $20 copay ▪ * **Out-of-Network** 35% coinsurance *
Acupuncture Medicare-covered	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. $30 copay for Medicare-covered Acupuncture received in a Specialist office. $20 copay for Medicare-covered Acupuncture received in a Chiropractor office. ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay for Medicare-covered Acupuncture received in a PCP office. $30 copay for Medicare-covered Acupuncture received in a Specialist office. $20 copay for Medicare-covered Acupuncture received in a Chiropractor office. ▪ * **Out-of-Network** 35% coinsurance *
Podiatry Services (Foot Care) Medicare Covered	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	**Wellcare No Premium (HMO-POS) H0174, Plan 012, 004**
	What you should know: Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.	**What you should know:** Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.
Virtual Visits	Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors via Teladoc to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more. A virtual visit (also known as a telehealth consult) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.	
Home health agency care	**In-Network** $0 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay ▪ * **Out-of-Network** 35% coinsurance *

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Additional Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Meals		
Post-Acute Meals	$0 copay for each post-acute meal ▪ **What you should know:** You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days.	$0 copay for each post-acute meal ▪ **What you should know:** You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days.
Chronic Meals	$0 copay for each chronic meal ▪ **What you should know:** You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modifications. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months.	$0 copay for each chronic meal ▪ **What you should know:** You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modifications. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months.

Services with an asterisk (*) may require prior authorization.
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Additional Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Medical Equipment/Supplies		
Durable Medical Equipment (DME)	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *
Prosthetics	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *
Diabetic supplies	**In-Network** $0 copay * **Out-of-Network** 35% coinsurance *	**In-Network** $0 copay * **Out-of-Network** 35% coinsurance *
Diabetic therapeutic shoes or inserts	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *	**In-Network** 20% coinsurance * **Out-of-Network** 35% coinsurance *

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Additional Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
Opioid treatment program services	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *	**In-Network** $30 copay ▪ * **Out-of-Network** 35% coinsurance *
Over-the-Counter (OTC) Items	$0 copay The maximum total benefit is $55 every three months **What you should know:** Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.	$0 copay The maximum total benefit is $55 every three months **What you should know:** Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.
Wellness Programs Fitness	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. $0 copay Coverage includes: Activity Tracker and Physical Fitness	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. $0 copay Coverage includes: Activity Tracker and Physical Fitness

Services with an asterisk (*) may require prior authorization.
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Additional Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	Wellcare No Premium (HMO-POS) H0174, Plan 012, 004
	What you should know: This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.	**What you should know:** This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.
Additional sessions of smoking and tobacco cessation counseling	**In-Network** $0 copay **Out-of-Network** Not covered Limited to 5 visit(s) every year	**In-Network** $0 copay **Out-of-Network** Not covered Limited to 5 visit(s) every year
Additional Routine Annual Physical	**In-Network** $0 copay **Out-of-Network** Not covered **What you should know:** Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.	**In-Network** $0 copay **Out-of-Network** Not covered **What you should know:** Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.

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

Additional Benefits

	Wellcare No Premium (HMO-POS) H0174, Plan 012, 001	**Wellcare No Premium (HMO-POS) H0174, Plan 012, 004**
24-Hour Nurse Advice Line	$0 copay	$0 copay
Special Supplemental Benefits for Chronically Ill (SSBCI) To qualify for these benefits you must meet specific criteria, including having a qualifying chronic condition and determined to be eligible for high-risk care management. For a complete list of eligibility criteria, please see the Evidence of Coverage.	Utility Flex Card: You pay $0 copay Plan covers up to $50 per month to help cover the cost of utilities for your home. Limitations apply. Referral may be required *	Utility Flex Card: You pay $0 copay Plan covers up to $50 per month to help cover the cost of utilities for your home. Limitations apply. Referral may be required *
Flex Card	$750 yearly benefit **What you should know:** The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier.	$750 yearly benefit **What you should know:** The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier.

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

ATENCIÓN: Si habla español, contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. Llame al 1-877-374-4056 (TTY: 711).

注意：如果您説中文，您可以免費獲得語言援助服務。請致電 1-877-374-4056 (TTY：711)。

Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí dành cho quý vị. Hãy gọi số 1-877-374-4056 (TTY: 711).

주의사항: 한국어를 구사할 경우, 언어 보조 서비스를 무료로 이용 가능합니다.
1-877-374-4056 (TTY: 711) 번으로 연락해 주십시오.

Atensyon: Kung nagsasalita ka ng Tagalog, may mga available na libreng tulong sa wika para sa iyo. Tumawag sa 1-877-374-4056 (TTY: 711).

Dumngeg: No agsasau ka iti Ilokano, dagiti tulong nga serbisio, a libre, ket available para kaniam. Awagan ti 1-877-374-4056 (TTY: 711).

La Silafia: Afai e te tautala i le gagana Sāmoa, gagana ‘au’aunaga fesoasoani, fai fua leai se totogi, o lo’o avanoa ia te ‘oe. Vala’au le 1-877-374-4056 (TTY: 711).

Maliu: Inā ‘ōlelo Hawai‘i ‘oe, he lawelawe māhele ‘ōlelo, manuahi, i lako iā ‘oe. E kelepona iā 1-877-374-4056 (TTY: 711).

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-917-0175 (TTY: 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Visit www.wellcare.com/medicare or call 1-844-917-0175 (TTY: 711) 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.

Understanding Important Rules

- ☐ **For plans with a plan premium (Does not apply to plans with zero plan premium):** 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, 2023.
- ☐ **For HMO plans only:** Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **For PPO and PFFS plans only:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ **For C-SNP plans only:** This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- ☐ **For D-SNP plans only:** 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.

Contact Us

For more information, please contact us:

By phone

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

Hours of Operation

Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

Online www.wellcare.com/medicare

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

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