January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services as a Member of Wellcare Patriot Simple (HMO)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Your plan premium and cost sharing
- Your medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 1-800-977-7522 (TTY users 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. This call is free.

This plan, Wellcare Patriot Simple (HMO), is offered by SUPERIOR HEALTHPLAN, INC. (When this *Evidence of Coverage* says "we," "us," or "our," it means SUPERIOR HEALTHPLAN, INC. When it says "plan" or "our plan," it means Wellcare Patriot Simple (HMO).)

This document is available for free in Spanish. We can send materials to you in a language other than English (in addition to the language(s) listed above) or in an alternate format (such as braille, audio, or large print). Please call Member Services if you need plan information in another format.

Benefits and/or copayments/coinsurance may change on January 1, 2028.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

OMB Approval 0938-1051 (Expires: July 31, 2029)
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Table of Contents

CHAPTER 1: Get started as a member 4

SECTION 1 You're a member of Wellcare Patriot Simple (HMO) 4

SECTION 2 Plan eligibility requirements 4

SECTION 3 Important membership material 5

SECTION 4 Summary of Important Costs for 2027 7

SECTION 5 More information about your monthly plan premium 8

SECTION 6 Keep your plan membership record up to date 8

SECTION 7 How other insurance works with our plan 9

CHAPTER 2: Phone numbers and resources 11

SECTION 1 Our plan contacts 11

SECTION 2 Get help from Medicare 14

SECTION 3 State Health Insurance Assistance Program (SHIP) 15

SECTION 4 Quality Improvement Organization (QIO) 16

SECTION 5 Social Security 17

SECTION 6 Medicaid 18

SECTION 7 Railroad Retirement Board (RRB) 18

SECTION 8 If you have group insurance or other health insurance from an employer 19

CHAPTER 3: Using our plan for your medical services 20

SECTION 1 How to get medical care as a member of our plan 20

SECTION 2 Use providers in our plan's network to get medical care 22

SECTION 3 How to get services in an emergency, disaster, or urgent need for care 26

SECTION 4 What if you're billed directly for the full cost of covered services? 28

SECTION 5 Medical services in a clinical research study 29

SECTION 6 Rules for getting care in a religious non-medical health care institution 30

SECTION 7 Rules for ownership of durable medical equipment 31

Table of Contents

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay) 33

SECTION 1 Understanding your out-of-pocket costs for covered services 33

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs 34

SECTION 3 Services that aren't covered by our plan (exclusions) 89

CHAPTER 5: Asking us to pay our share of a bill for covered medical services 93

SECTION 1 Situations when you should ask us to pay our share for covered services 93

SECTION 2 How to ask us to pay you back or pay a bill you got 94

SECTION 3 We'll consider your request for payment and say yes or no 95

CHAPTER 6: Your rights and responsibilities 97

SECTION 1 Our plan must honor your rights and cultural sensitivities 97

SECTION 2 Your responsibilities as a member of our plan 103

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints) 105

SECTION 1 What to do if you have a problem or concern 105

SECTION 2 Where to get more information and personalized help 105

SECTION 3 Which process to use for your problem 106

SECTION 4 A guide to coverage decisions and appeals 106

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal 109

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon 116

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon 121

SECTION 8 Taking your appeal to Levels 3, 4 and 5 124

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns 126

CHAPTER 8: Ending membership in our plan 131

SECTION 1 Ending your membership in our plan 131

Table of Contents

SECTION 2 When can you end your membership in our plan? ... 131
SECTION 3 How to end your membership in our plan ... 133
SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan ... 134
SECTION 5 Wellcare Patriot Simple (HMO) must end your plan membership in certain situations ... 134

CHAPTER 9: Legal notices ... 136
SECTION 1 Notice about governing law ... 136
SECTION 2 Notice about nondiscrimination ... 136
SECTION 3 Notice about Medicare Secondary Payer subrogation rights ... 136
SECTION 4 Recovery of benefits paid by our plan under your Wellcare Patriot Simple (HMO) plan ... 137
SECTION 5 Membership card ... 139
SECTION 6 Independent contractors ... 139
SECTION 7 Health care plan fraud ... 139
SECTION 8 Circumstances beyond the plan's control ... 140

CHAPTER 10: Definitions ... 141

CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Wellcare Patriot Simple (HMO)

Section 1.1 You're enrolled in Wellcare Patriot Simple (HMO), which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Wellcare Patriot Simple (HMO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Wellcare Patriot Simple (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Wellcare Patriot Simple (HMO) *doesn't* include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in our plan between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of our plan after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for Wellcare Patriot Simple (HMO)

Wellcare Patriot Simple (HMO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Texas: Armstrong, Atascosa, Bailey, Bandera, Bexar, Blanco, Borden, Briscoe, Castro, Collin, Comal, Crosby, Dallas, Denton, DeWitt, Ector, El Paso, Ellis, Fisher, Floyd, Garza, Glasscock, Gonzales, Guadalupe, Hockley, Hood, Kendall, Kent, La Salle, Lamb, Lubbock, Lynn, Martin, Medina, Milam, Nolan, Parker, Potter, Randall, Real, Rockwall, Shackelford, Sterling, Swisher, Tarrant, Terry, Throckmorton, Uvalde, Wilson, Wise, and Zavala.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-800-977-7522 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Wellcare Patriot Simple (HMO) if you're not eligible to stay a member of our plan on this basis. Wellcare Patriot Simple (HMO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership material

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:

DON'T use your red, white and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Wellcare Patriot Simple (HMO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-800-977-7522 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* go.wellcare.com/2027providerdirectories lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

A Medical Group is an association of physicians, including Primary Care Providers (PCPs) and specialists, and other health care providers, including hospitals, that contract with an HMO to provide services to enrollees.

You must use network providers to get your medical care and services. The providers in Wellcare Patriot Simple (HMO) are grouped by Local Physician Organizations (LPOs), which are headed by Primary Care Providers (PCPs). A member's choice of PCP will determine which LPOs providers are in their referral network. This means that the PCP that you choose may determine the specialists and hospitals you can use. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Wellcare Patriot Simple (HMO) authorizes use of out-of-network providers.

Get the most recent list of providers and suppliers on our website at go.wellcare.com/2027providerdirectories.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-800-977-7522 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	**$0**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	**$3,400**
Primary care office visits	**$0 copay per visit**
Specialist office visits	**$10 copay per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**For Medicare-covered admissions, per admission:** **$275 copay per day, for days 1 to 5 and $0 copay per day, for days 6 to 90 for each hospital stay.**

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for our plan.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2027* handbook in the section called *2027 Medicare*

Costs. Download a copy from the Medicare website (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums.

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A, if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly plan premium

Section 5.1 Your monthly plan premium won't change during the year

We're not allowed to change your plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, and other providers in your plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room

- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note**: You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 1-800-977-7522 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-800-977-7522 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("the secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 Our plan contacts

For help with claims, billing, or member card questions, call or write to Wellcare Patriot Simple (HMO). We'll be happy to help you.

Member Services – Contact Information	
Call	1-800-977-7522 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. If you leave a voicemail message, please include your name, and telephone number and a team member will return your call within one (1) business day. Member Services 1-800-977-7522 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
Write	Wellcare By Allwell PO Box 10420 Van Nuys, CA 91410-0420
Website	go.wellcare.com/TX

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical

care, go to Chapter 7.

Coverage Decisions for Medical Care – Contact Information	
Call	1-800-977-7522 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
Write	Coverage Determinations Department - Medical PO Box 10420 Van Nuys, CA 91410-0420

Appeals for Medical Care – Contact Information	
Call	1-800-977-7522 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
Fax	1-844-273-2671
Write	MEMBER Appeals & Grievances Medicare Operations Appeals Department - Medical P.O. Box 10343 Van Nuys, CA 91410-0343

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	1-800-977-7522 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
Fax	1-844-273-2671
Write	Appeals & Grievances Medicare Operations Grievance Department P.O. Box 10344 Van Nuys, CA 91410-0344
Medicare website	To submit a complaint about Wellcare Patriot Simple (HMO) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Write	Member Reimbursement Dept Medical Reimbursement Department PO Box 10420 Van Nuys, CA 91410-0420
Website	go.wellcare.com/TX

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044

Medicare – Contact Information	
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about our plan. **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Texas, the SHIP is called Texas Department of Aging and Disability Services (HICAP).

Texas Department of Aging and Disability Services (HICAP) is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Texas Department of Aging and Disability Services (HICAP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Texas Department of Aging and Disability Services (HICAP) counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices and answer questions about switching plans.

Texas Department of Aging and Disability Services (HICAP) – Contact Information	
Call	1-800-252-9240 1-877-787-8999
TTY	1-800-735-2989 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Texas Department of Aging and Disability Services 701 West 51st Street, MC: W275 Austin, TX 78711-3247
Website	https://www.hhs.texas.gov/services/health/medicare

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Texas, the Quality Improvement Organization is called Acentra Health (Texas's Quality Improvement Organization).

Acentra Health (Texas's Quality Improvement Organization) has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Acentra Health (Texas's Quality Improvement Organization) is an independent organization. It's not connected with our plan.

Contact Acentra Health (Texas's Quality Improvement Organization) in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Acentra Health (Texas's Quality Improvement Organization) – Contact Information	
Call	1-888-315-0636 9:00 a.m. - 5:00 p.m. local time, Monday - Friday; 10:00 a.m. - 4:00 p.m. local time, weekends and holidays
TTY	711
Write	Acentra Health/Texas's Quality Improvement Organization 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317
Website	https://www.acentraqio.com/

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, contact Social Security to let them know.

Social Security— Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact Texas Medicaid.

Texas Medicaid – Contact Information	
Call	1-877-541-7905 1-512-424-6500 211 8:00 a.m. - 4:00 p.m. CT, Monday - Friday
TTY	711 1-800-735-2989 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	Texas Health and Human Services North Austin Complex 4601 W. Guadalupe St. P.O. Box 13247 Austin, TX 78751-3146
Website	https://hhs.texas.gov/services/health/medicaid-chip

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the

Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-800-977-7522 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.

- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 of this chapter for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. *Here are 3 exceptions:*
    - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
    - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Please call us to find out about the authorization rules that you may need to follow prior to seeking care. In this situation, you pay the same as you'd pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
    - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

When you become a member of our plan, you must first choose a plan provider to be your PCP. Your PCP is your partner in health, providing or coordinating your care. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. These include doctors specializing in family practice, general practice, internal medicine, and geriatrics. A nurse practitioner (NP), a State licensed registered nurse with special training, providing a basic level of health care, or a Physician Assistant (PA), credentialed as a PCP, providing services within a primary care setting can also act as your PCP.

You will get most of your routine or basic care from your PCP. Your PCP will also help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes:

- X-rays,
- Laboratory tests,
- Physical, Occupational and/or Speech Therapies,
- Care from doctors who are specialists,
- Hospital admissions, and
- Follow-up care

"Coordinating" your covered services includes checking or consulting with other plan providers about your care and how it is going. For certain types of services or supplies, your PCP will need to get prior authorization (approval in advance). If the service you need requires prior authorization, your PCP will request the authorization from our plan. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. You will usually see your PCP first for most of your routine health care needs. We recommend you have your PCP coordinate all of your care. Please refer to Section 2.3 in this chapter for more information.

In some cases, your PCP, or a specialist or other provider you're seeing, will need to obtain prior authorization (prior approval) from us for certain types of covered services and items. See Chapter 4 of this document for services and items that require prior authorization.

If you need to talk to your physician after normal business hours, call the physician's office and you will be directed to your physician, an answering machine with directions on where to obtain service, or another physician that is providing coverage. If you are experiencing an emergency, immediately call 911.

How to choose a PCP?

To choose your PCP, go to our website at go.wellcare.com/2027providerdirectories and select a PCP from our plan network. Member Services can also help you choose a PCP. Once you have chosen your PCP call Member Services with your selection. Your PCP must be in our network.

If there is a particular plan specialist or hospital that you want to use, check first to be sure that the specialists and/or hospitals are in the PCP's network.

If you do not choose a PCP or if you chose a PCP that is not available with this plan, we will automatically assign you to a PCP.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. Under certain circumstances, our providers are obligated to continue care after leaving our network. For specific details, contact Member Services.

If you wish to change your PCP, please call Member Services. Each plan PCP may make referrals to certain plan specialists and uses certain hospitals within their network. Because some PCPs participate in limited or specific referral networks, the plan PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your plan PCP uses these specialists or hospitals.

To change your PCP, call Member Services. The change will be effective the first day of the following month. Please Note: If you use a PCP other than the PCP you are assigned to, you may incur a higher cost share or your claims may be denied.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like

annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-800-977-7522 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

In order for you to see a specialist, you usually need to get your PCP's approval first. This is called getting a "referral" to a specialist. It is very important to get a referral from your PCP before you see a plan specialist or certain other providers. There are a few exceptions, including routine women's health care, as explained in Section 2.2. If you don't have a referral before you get services from a specialist or certain other providers, you may have to pay for these services yourself.

If the specialist wants you to come back for additional care, check first to be sure that the referral you got from your PCP for the first visit covers additional visits to the specialist or certain other providers. In some cases, you, your representative or your PCP/provider may need to get prior authorization from the plan. Please see Chapter 4, Section 2 for information about which services require prior authorization.

Each plan PCP may make referrals to certain plan specialists and uses certain hospitals within their network. Because some PCPs participate in limited or specific referral networks, the PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your plan PCP uses these specialists or hospitals. You may generally change your PCP at any time if you want to see a plan specialist or go to a hospital that your current PCP can't refer you to. In Section 2.1 under "How to change your PCP," we tell you how to change your PCP.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.

- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Our plan must confirm there is not a network provider available, and the out-of-network provider must contact the plan to request an authorization for you to obtain services. If approved, the out-of-network provider will be issued an authorization to provide the service(s). You are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, our plan must cover dialysis services for members with End-Stage Renal Disease (ESRD) who have traveled outside the plan's service area and are not able to access network providers. ESRD services must be received at a Medicare-certified dialysis facility.
- If you find out your doctor or specialist is leaving our plan, call Member Services at 1-800-977-7522 (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7)

Section 2.4 How to get care from out-of-network providers

You are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, our plan must cover dialysis services for members with End-Stage Renal Disease (ESRD) who have traveled outside the plan's service area and are not able to access network providers. ESRD services must be received at a Medicare-certified dialysis facility.

Also, if you need Medicare-covered medical care and a network provider is unable to provide this care, you may be able to get care from an out-of-network provider. Our plan must confirm there is not a network provider available, and the out-of-network provider must contact the plan to request an authorization for you to obtain services. If approved, the out-of-network provider will be issued an authorization to provide the service(s).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. Wellcare Patriot Simple (HMO) includes world-wide emergency/urgent coverage.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You can call Member Services at the number located on the back of your membership card.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're entitled to medically necessary follow up care to make sure your condition continues to be stable. Your doctors will continue to treat you until your medical condition is stable and, when appropriate, will work with us to plan any additional care.

It is generally recommended that you follow up with your primary care provider or treating provider within 5 to 7 days after receiving emergency care to support your recovery. However, follow up care is

not required for your emergency services to be covered, and your coverage is not affected if you are unable to schedule a follow up visit within a specific timeframe.

As part of our care coordination services, you may receive outreach from our care team to help you schedule follow up appointments or connect you with additional resources, if needed. Any medically necessary follow up care covered by your plan will be paid according to your plan's cost sharing rules.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Please contact your PCP's office 24 hours a day if you need urgent care. You may be directed to obtain urgent care at a network urgent care center. A list of network urgent care centers can be found in the *Provider Directory* or on our website at go.wellcare.com/2027providerdirectories. If urgent care services are received in your doctor's office, you will pay the office visit copayment; however, if urgent care services are received at a network urgent care center or walk-in clinic, you will pay the urgent care center copayment, which may be different. See the Medical Benefits Chart in Chapter 4 for the copayment that applies to services provided in a doctor's office or network urgent care center or walk-in clinic.

You may also contact the Nurse Advice Line at any time. A nursing professional is standing by with answers to your questions 24 hours a day, seven days a week. For more information regarding the

Advice Line see the Health and Wellness Education Programs benefit category in Chapter 4, or call Member Services.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances. However, Medicare does not cover emergency care outside of the United States.

- You are covered for up to $50,000 when traveling outside of the United States under your worldwide emergency and urgent care coverage. Costs that exceed this amount will *not* be covered.
- Transportation back to the United States from another country and medication purchased while outside of the United States are *not* covered. Additionally, emergency room cost shares are *not* waived if you are admitted for inpatient hospital care.
- Please contact us within 48 hours, if possible, to advise us of your emergency room visit.

For more information, see "Emergency Care" and "Urgently Needed Services" in the Medical Benefits Chart in Chapter 4 of this document or call Member Services.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit go.wellcare.com/TX for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. The amount you pay for the costs once a benefit limit has been reached will not count toward the out-of-pocket maximum. For example, you may have to pay the full cost of any skilled nursing facility care you get after our plan's payment reaches the benefit limit. Once you have used up your benefit limit, additional payments you make for the service do not count toward your annual out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, then you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that include require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational exemption device (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following**:

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's voluntary and not required by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care;
    - – *and* – You must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Your stay in a religious non-medical health care institution is not covered by our plan unless you obtain authorization (approval) in advance from our plan and will be subject to the same coverage limitations as the inpatient or skilled nursing facility care you would otherwise have received. Please refer to the Medical Benefits Chart in Chapter 4 for coverage rules and additional information on cost sharing and limitations for inpatient hospital and skilled nursing coverage.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of our plan, there are certain types of DME you will own after paying copayments for the item for a specified number of months. Your previous**

payments towards a DME item when you had Original Medicare do not count towards payments you make while a member of our plan. If you acquire ownership of a DME item while you are a member of our plan, and the equipment requires maintenance, the provider is allowed to bill the plan for the cost of the repair. There are also certain types of DME for which you will not acquire ownership no matter how many payments you make for the item while a member of our plan. Call Member Services at 1-800-977-7522 (TTY users call 711) to find out about the rental or ownership requirements of DME and the documentation you need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies and maintenance

If you qualify for Medicare oxygen equipment coverage, Wellcare Patriot Simple (HMO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Wellcare Patriot Simple (HMO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of our plan. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is $3,400.**

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $3,400 , you won't have to

pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of our plan, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
    - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-800-977-7522 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services our plan covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements.	$0 copay for Medicare-covered acupuncture received in a PCP office. $10 copay for Medicare-covered acupuncture received in a Specialist office. *Referral may be required.* *Prior Authorization may be required.* $10 copay for Medicare-covered acupuncture received in a Chiropractor office. *Referral may be required.* *Prior Authorization may be required.*

Covered Service	What you pay
Acupuncture for chronic low back pain - continued Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$225 copay per one-way trip for Medicare-covered ground ambulance services. *Prior Authorization may be required for fixed wing aircraft and non-emergent transportation.* $225 copay per one-way trip for Medicare-covered air ambulance services. *Prior Authorization may be required for fixed wing aircraft and non-emergent transportation.* The cost share is not waived if you are admitted for Inpatient hospital care.

Covered Service	What you pay
Annual routine physical exam Annual physical exam includes examination of the heart, lung, abdominal and neurological systems, as well as a hands-on examination of the body (such as head, neck and extremities) and detailed medical/family history, in addition to services included in the Annual Wellness Visit. The following are examples of services that may be performed or ordered during your exam: • Take routine measurements (height, weight, blood pressure) • Assess risk factors for preventable diseases • Check reflexes and vital signs • Lab testing (urine and blood samples)	$0 copay for an annual routine physical exam.*
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Covered Service	What you pay
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$55 copay for Medicare-covered cardiac rehabilitation services. *Referral may be required.* $70 copay for Medicare-covered intensive cardiac rehabilitation services. *Referral may be required.*

Covered Service	What you pay
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct a vertebral subluxation	$10 copay for Medicare-covered chiropractic services. *Referral may be required.*

Covered Service	What you pay
Chiropractic services - continued *Prior Authorization may be required.*	
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and subject to a $0 copay for your doctors' services.

Covered Service	What you pay
Colorectal cancer screening - continued • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: **Supplemental (i.e., routine) dental services** There is a plan benefit maximum of $3,000 every year for covered Comprehensive Dental services. You are responsible for amounts beyond the benefit limit.* • **Diagnostic and Preventive Dental Care** Covered services include the following ○ Periodic Oral exams - 2 every year	$10 copay for each Medicare-covered dental service. *Prior Authorization may be required.* $0 copay for each oral exam.* *Prior Authorization may be required.*

Covered Service	What you pay
Dental services - continued	
○ Cleanings (prophylaxis) - 2 every year	$0 copay for each cleaning.* *Prior Authorization may be required.*
○ Fluoride treatment - 1 every year	$0 copay for each fluoride treatment.* *Prior Authorization may be required.*
○ Dental x-rays - 1 set(s) every date of service to 3 years depending on type of service	$0 copay for dental x-rays per visit.* *Prior Authorization may be required.*
○ Other Diagnostic dental services - 1 per visit	$0 copay for other diagnostic dental services per visit.* *Prior Authorization may be required.*
○ Other Preventive Dental services - 1 per tooth per 6 months	$0 copay for other preventive dental services per visit.* *Prior Authorization may be required.*
• **Comprehensive Dental Care** Covered services include the following	
○ Restorative services - 1 every 1 to 7 plan years per tooth depending on type of service	$0 copay for each restorative service.* *Prior Authorization may be required.*

Covered Service	What you pay
Dental services - continued	
○ Endodontics - 1 per tooth per lifetime	$0 copay for each endodontic service.* *Prior Authorization may be required.*
○ Periodontics - 1 every 6 months to per lifetime depending on type of service	$0 copay for each periodontic service.* *Prior Authorization may be required.*
○ Oral/Maxillofacial surgery - 1 every date of service to per lifetime depending on type of service	$0 copay for each oral maxillofacial service. * *Prior Authorization may be required.*
○ Prosthodontics, fixed - 1 every 2 to 7 years per tooth depending on the type of service	$0 copay for each fixed prosthodontic service.* *Prior Authorization may be required.*
○ Prosthodontics, removable - 1 every year to 5 years depending on type of service	$0 copay for each removable prosthodontic service. * *Prior Authorization may be required.*
○ Adjunctive general services - 1 every date of service to every 5 years depending on type of service	$0 copay for each adjunctive general service. * *Prior Authorization may be required.*
Before obtaining services, members are advised to discuss their treatment options with a routine dental services participating provider. Treatment must be started and completed while covered by the plan during the plan year. The cost of dental	

Covered Service	What you pay
Dental services - continued services not covered by the plan is the responsibility of the member. **Supplemental (i.e., Non-Medicare covered routine) dental services must be received from a participating provider in order to be covered by the plan.** **For questions on how to find a provider, file a claim, or for more information call Member Services.** **You can find additional dental coverage information, including a detailed list of covered procedures, in our Dental Benefit Details at:** go.wellcare.com/dental-gold	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:	$0 copay for Medicare-covered blood glucose monitor

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies - continued	
• Supplies to monitor your blood glucose: blood glucose monitor (traditional finger stick blood glucose monitor), continuous glucose monitors (CGM), blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	(traditional finger stick blood glucose monitor). *Prior Authorization may be required.* $0 copay for Medicare-covered continuous glucose monitors (CGM). *Prior Authorization may be required.* $0 copay for Medicare-covered blood glucose test strips, lancet devices and lancets, and glucose control solutions. *Prior Authorization may be required.*
• For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting.	20% coinsurance for Medicare-covered therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. *Prior Authorization may be required.*
• Diabetes self-management training under certain conditions.	$0 copay for Medicare-covered diabetes self-management training. *Referral may be required.*

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies - continued Accu-Chek™ Guide and True Metrix™ are our preferred diabetic testing supplies (glucose monitors & test strips). Dexcom and FreeStyle Libre are our preferred continuous glucose monitor brands. To get more information about the items that are on the preferred diabetic testing and monitoring supply lists, please contact Member Services. If you use diabetic testing and monitoring supplies that are not preferred by the plan, speak with your provider to get a new prescription or to request prior authorization for a non-preferred blood glucose monitor and test strips.	
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at go.wellcare.com/2027providerdirectories.	20% coinsurance for Medicare-covered durable medical equipment. *Prior Authorization may be required.* 20% coinsurance for Medicare-covered medical supplies. *Prior Authorization may be required.* Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance, every 36 months.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies - continued	Your cost sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost sharing in our plan is 20% coinsurance.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	$150 copay for Medicare-covered emergency room visits. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.

Covered Service	What you pay
Emergency care - continued	
Emergency services outside the United States are covered.	$150 copay for emergency services outside of the United States.* You pay this amount even if you are admitted to the hospital for the same condition. You are covered for up to $50,000 every year for emergency or urgently needed services outside the United States.
Health and wellness education programs	
• **Nurse advice line** Toll-free telephonic Nurse Advice Line staffed by trained, licensed registered nurses, available 24 hours a day, 7 days a week. Nurses provide guidance for health-related questions, help members determine the most appropriate level of care, and offer support for non-emergency health concerns. You can access the Nurse Advice Line by calling Member Services and requesting a transfer to the Nurse Advice Line.	$0 copay for the nurse advice line.*
• **Fitness benefit** Our plan provides a fitness program that offers access to fitness locations nationwide. To help support an active and healthy lifestyle, you have access to the following features at no cost: ○ Fitness Center Membership: Choose from a number of in-person fitness centers that participate in the fitness network. Membership includes access to standard fitness club or fitness studio services as well as group workout classes offered. You may	$0 copay for the fitness benefit.*

Covered Service	What you pay
Health and wellness education programs - continued access one or more gyms within the fitness network. ○ Home Fitness Kits: You may choose from a variety of home fitness kits. You can receive up to 1 kit per benefit year. ○ Digital Fitness Program: Choose from thousands of on-demand workout videos through the digital library, access to virtual classes, and a mobile app. For more information regarding the fitness benefit, please call Member Services.	
• **Personal emergency response system (PERS)** Coverage for one personal emergency medical response device and monitoring services. A personal emergency medical response device provides peace of mind and 24/7 response to your emergent and non-emergent needs. Members can choose from: ○ In-home PERS, with landline or cellular connectivity options. Includes base unit and additional wearables. ○ Mobile PERS, includes neck pendants, watchband, and belt clip wearable options. ○ PERS Smartwatch, includes step tracking, heart rate monitoring and location technology features. Included with PERS device is access to an app for you and your family caregivers and/or emergency contacts. The app provides real-time visibility into activity, alerts, and device status for added safety and peace of mind. You may also manage features, settings, and preferences for your device through the app. To find out more information call Member Services.	$0 copay for Personal Emergency Response System (PERS) – Medical Alert System.*

Covered Service	What you pay
Hearing services	
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$10 copay for each Medicare-covered hearing exam. *Prior Authorization may be required.*
Our plan also covers the following supplemental (i.e., routine) hearing services:	
• 1 routine hearing exam every year.	$0 copay for 1 routine hearing exam every year.* *Prior Authorization may be required.*
• 1 hearing aid fitting and evaluation every year.	$0 copay for 1 hearing aid fitting and evaluation every year.* *Prior Authorization may be required.*
• 1 non-implantable hearing aid up to $750 per ear every year. Limited to 2 non-implantable hearing aids every year. Benefit includes a 3-year warranty including loss, and damage with a supply of batteries. Any hearing aid costs that exceed the benefit maximum above are your responsibility. Additional hearing aids are not covered.	$0 copay for 2 hearing aid(s) every year.* *Prior Authorization may be required.*
Routine hearing services must be received from a participating provider within the vendor network in order to receive the full hearing benefit covered by the plan. For more information on your hearing vendor, contact information and benefits, please call Member Services.	

Covered Service	What you pay
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copay for each Medicare-covered home health agency care service. *Referral may be required.* *Prior Authorization may be required.*
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).	$0 copay for professional services from a Primary Care Provider (PCP), including nursing services, training and education, remote monitoring and monitoring services.

Covered Service	What you pay
Home infusion therapy - continued Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	$10 copay for professional services from a specialist, including nursing services, training and education, remote monitoring and monitoring services. *Referral may be required.* *Prior Authorization may be required.* Home infusion equipment and supplies are covered under your Durable Medical Equipment (DME) benefit. Please see the "Durable medical equipment (DME) and related supplies" section for cost sharing information. Home infusion drugs are covered under your Medicare Part B Prescription Drugs benefit. Please see the "Medicare Part B Prescription Drugs" section for cost sharing information.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.

Covered Service	What you pay
Hospice care - continued financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by our plan but not covered by Medicare Part A or B:** Our plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.	Physician service cost sharing may apply for hospice consultation services. See the "Physician/ Practitioner Services" section of this chart for information on cost sharing.

Covered Service	What you pay
Hospice care - continued **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. For other Medicare-covered vaccines (if you are at risk and they meet Medicare Part B coverage rules), please refer to the Medicare Part B prescription drugs section of this chart for applicable cost sharing. *Some Part B drugs require prior authorization to be covered.*
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the	For Medicare-covered admissions, per admission: $275 copay per day, for days 1 to 5, and $0 copay per day, for days 6 to 90 for each hospital stay. $0 copay for unlimited additional days.*

Covered Service	What you pay
Inpatient hospital care - continued	
hospital with a doctor's order. The day before you're discharged is your last inpatient day. You are covered for unlimited days for Medicare-covered inpatient hospital stays. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the first	If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. *Original Medicare covers 90 days of acute inpatient hospital care. Our plan offers an additional unlimited number of days when medically necessary. Cost share, if any, for these days does not apply to your out-of-pocket maximum. *Referral may be required.* *Prior Authorization may be required.* Medicare hospital benefit periods do not apply. For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility (such as Acute Inpatient Rehabilitation Hospital or to another Acute care Hospital) is considered a new admission. Cost shares are applied starting on the first day of admission

Covered Service	What you pay
Inpatient hospital care - continued pint of blood you need. All other components of blood are covered starting with the first pint. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an *outpatient*, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	and do not include the date of discharge.
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. You are covered for 90 days per admission for Medicare-covered stays. There is a 190-day lifetime limit for inpatient mental health services provided in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. If you have used part of the 190-day Medicare lifetime benefit prior to enrolling in our plan, then you are only entitled to receive the remainder of your lifetime days.	For Medicare-covered admissions, per admission: $225 copay per day, for days 1 to 5, and $0 copay per day, for days 6 to 90 for mental health care. Lifetime Reserve Days $0 copay per day. Lifetime Reserve Days are additional days that the plan will pay for when members are in a hospital for more than the number of days covered by the plan. Members have a total of 60 reserve days that can be used during their lifetime. *Referral may be required.*

Covered Service	What you pay
Inpatient services in a psychiatric hospital - continued	*Prior Authorization may be required.* If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. Medicare hospital benefit periods do not apply. For inpatient mental health care, the cost sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility (such as Acute Inpatient Rehabilitation Hospital or to another Acute care Hospital) is considered a new admission. Cost shares are applied starting on the first day of admission and do not include the date of discharge.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while	The listed services will continue to be covered at the cost sharing amounts shown in the benefits chart for the specific service.

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay - continued you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	
Meals **Post-Acute meals** • For members discharged from an inpatient hospital facility the plan will provide a maximum of 2 meals per day for 14 days for a total of 28 meals at no cost to you. Services must be requested within 45 days of discharge from your inpatient stay. Subject to availability, you may choose to receive fresh frozen meals, refrigerated meals, or nutritional shakes. You may choose to receive a combination of meals and shakes within your total benefit limit.	$0 copay for each medically necessary post-acute meal or shake covered by the plan.* *Referral may be required.*

Covered Service	What you pay
Meals - continued	
Chronic Meals Members under care management with certain chronic conditions may be eligible to receive healthy meals as part of a supervised program to transition you to lifestyle modifications. • Eligible chronic conditions include AIDS, asthma, chronic obstructive pulmonary disease (COPD), chronic heart failure, coronary artery disease, diabetes, and hypertension. • You may receive a maximum of 2 healthy meals per day for up to 28 days for a maximum of 56 meals per month. This benefit may be used for a maximum of 3 months per year. • Subject to availability, you may choose to receive fresh frozen meals, refrigerated meals, or nutritional shakes. You may choose to receive a combination of meals and shakes within your monthly limit.	$0 copay for each medically-necessary chronic meal or shake covered by the plan. * *Referral may be required.*
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP) - continued physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.	
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug	Some drugs may be subject to step therapy. **Medicare Part B Insulin Drugs** $35 copay for Medicare-covered Part B insulin drugs. You pay no more than $35 per month supply of each covered insulin product. *Prior Authorization may be required.* **Other Medicare Part B Drugs** 0% coinsurance for Medicare-covered Part B allergy antigens. 20% coinsurance for all other Medicare-covered Part B drugs. *Prior Authorization may be required.*

Covered Service	What you pay
Medicare Part B drugs - continued • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Retacrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: go.wellcare.com/TXStepTherapy We also cover some vaccines under our Part B drug benefit.	**Medicare Part B Chemotherapy/ Radiation Drugs** 20% coinsurance for Medicare-covered Part B chemotherapy drugs. *Prior Authorization may be required.* **Certain Part B rebatable drugs may be subject to a lower coinsurance than the amount shown above.**

Covered Service	What you pay
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$10 copay for each Medicare-covered opioid treatment service. *Referral may be required.* *Prior Authorization may be required.*
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays	$25 copay for Medicare-covered X-rays. *Referral may be required.* *Prior Authorization may be required.*

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies - continued	
• Radiation (radium and isotope) therapy including technician materials and supplies	20% coinsurance for Medicare-covered therapeutic radiology services. *Referral may be required.* *Prior Authorization may be required.*
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations	20% coinsurance for Medicare-covered medical supplies including casts and splints. *Prior Authorization may be required.*
• Laboratory tests	$50 copay for Medicare-covered genetic testing. $0 copay for all other Medicare-covered lab services. *Referral may be required.* *Prior Authorization may be required.*
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.	$0 copay for Medicare-covered blood services. *Referral may be required.*
• Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem	$0 copay for Medicare-covered diagnostic mammogram.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies - continued	
	$200 copay for all other Medicare-covered diagnostic radiology services received in an outpatient setting. $75 copay for all other Medicare-covered services received in other settings (such as a physician office or freestanding facility). *Referral may be required.* *Prior Authorization may be required.*
• Other outpatient diagnostic tests	$0 copay for Medicare-covered diagnostic procedures and tests. *Referral may be required.* *Prior Authorization may be required.*
Outpatient hospital observation	
Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state	$150 copay for outpatient observation services when you enter observation status through an emergency room. $200 copay for outpatient observation services when you

Covered Service	What you pay
Outpatient hospital observation - continued licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	enter observation status through an outpatient facility. Additional costs will apply for Medicare Part B prescription drugs *Referral may be required.*
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	You pay the applicable cost sharing amounts shown in this Medical Benefits Chart for the specific service.

Covered Service	What you pay
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	
• Services provided by a psychiatrist	$0 copay for each Medicare-covered individual therapy visit with a psychiatrist. *Referral may be required.* *Prior Authorization may be required.* $0 copay for each Medicare-covered group therapy visit with a psychiatrist. *Referral may be required.* *Prior Authorization may be required.*
• Services provided by other mental health care providers	$0 copay for each Medicare-covered individual therapy visit with other mental health care providers. *Referral may be required.* *Prior Authorization may be required.* $0 copay for each Medicare-covered group

Covered Service	What you pay
Outpatient mental health care - continued	
	therapy visit with other mental health care providers. *Referral may be required.* *Prior Authorization may be required.*
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	
• Services provided by a physical therapist	$10 copay for each Medicare-covered physical therapy visit. *Referral may be required.* *Prior Authorization may be required.*
• Services provided by an occupational therapist	$10 copay for each Medicare-covered occupational therapy visit. *Referral may be required.* *Prior Authorization may be required.*
• Services provided by a speech language therapist	$10 copay for each Medicare-covered speech language therapy visit. *Referral may be required.*

Covered Service	What you pay
Outpatient rehabilitation services - continued	*Prior Authorization may be required.*
Outpatient substance use disorder services Covered services include: Substance Use Disorder services such as individual and group therapy sessions provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional or program, as allowed under applicable state laws.	$0 copay for each Medicare-covered individual therapy visit. *Referral may be required.* *Prior Authorization may be required.* $0 copay for each Medicare-covered group therapy visit. *Referral may be required.* *Prior Authorization may be required.*
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. • Services provided at an outpatient hospital	$0 copay for Medicare-covered skin biopsies.

Covered Service	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - continued	
	$200 copay for all other Medicare-covered outpatient services. *Referral may be required.* *Prior Authorization may be required.*
• Services provided at an ambulatory surgical center	$125 copay for each Medicare-covered visit to an ambulatory surgical center. *Referral may be required.* *Prior Authorization may be required.*
Partial hospitalization services and intensive outpatient services	
Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	$190 copay per day for each Medicare-covered partial hospitalization service. *Referral may be required.* *Prior Authorization may be required.*
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$200 copay per day for each Medicare-covered intensive outpatient service. *Referral may be required.* *Prior Authorization may be required.*

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits	
Covered services include:	
• Medically necessary medical care or surgery services you get in a physician's office by a primary care provider	$0 copay for each Medicare-covered PCP office visit.
• Medically-necessary medical care or surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location	See "Outpatient Surgery" earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting.
• Consultation, diagnosis, and treatment by a specialist	$10 copay for each Medicare-covered specialist visit. *Referral may be required.* *Prior Authorization may be required.*
• Other health care professionals	$0 copay for services received from other healthcare professionals in a PCP's office. $10 copay for services received from other healthcare professionals in all other locations. *Referral may be required.* *Prior Authorization may be required.*

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
• Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment	$10 copay for Medicare-covered hearing services. *Prior Authorization may be required.*
• Certain telehealth services, including: Urgently Needed Services, Home Health Services, Primary Care Physician, Occupational Therapy, Specialist, Individual and Group Sessions for Mental Health, Podiatry Services, Other Health Care Professional, Individual and Group Sessions for Psychiatric, Physical Therapy and Speech-Language Pathology Services, Individual and Group Sessions for Outpatient Substance Abuse, and Diabetes Self-Management Training. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ○ A virtual visit (also known as telehealth or telemedicine) 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. ○ Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors through virtual visit network providers to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more. For more information, or to find a virtual visit network provider call Member Services.	$0 copay for virtual visit services performed through your plan's virtual visit provider(s). **Please note:** The $0 copay above, only applies when services are received from your plan's virtual visit provider(s). If you receive in-person or telemedicine services from a network provider and not the virtual visit provider(s), you will pay the cost shares listed for those providers, as outlined within this benefit chart (e.g., if you receive telehealth services from your PCP, you will pay the PCP cost share). *Referral may be required.*
• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare.	

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost sharing that applies to the provider (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost sharing that applies to the provider (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	You will pay the cost sharing that applies to the provider (as described under

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits - continued	
	"Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Second opinion by another network provider prior to surgery	You will pay the cost sharing that applies to the provider (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
	In addition to the cost shares above, there will be a copay and/or coinsurance for Medically Necessary Medicare-covered Services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, eyeglasses and contacts after cataract surgery, and Medicare Part B prescription drugs, as described in this Benefit Chart.
Podiatry services	
Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$10 copay for Medicare-covered podiatry services. *Referral may be required.*

Covered Service	What you pay
Podiatry services - continued	*Prior Authorization may be required.*
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam	$0 copay for the Medicare-covered annual digital rectal exam. *Referral may be required.*
• Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	20% coinsurance for Medicare-covered prosthetic or orthotics. *Prior Authorization may be required.* 20% coinsurance for Medicare-covered medical supplies related to prosthetic devices. *Prior Authorization may be required.*
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$40 copay for each Medicare-covered pulmonary rehabilitation services visit. *Referral may be required.*
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Covered Service	What you pay
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

Covered Service	What you pay
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Kidney disease and dialysis services include:	
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime	20% coinsurance for Medicare-covered kidney disease education services. *Referral may be required.*
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	20% coinsurance for Medicare-covered outpatient renal dialysis treatments. *Referral may be required.*
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	See "Inpatient Hospital Care" for cost shares applicable to inpatient dialysis treatments.

Covered Service	What you pay
Services to treat kidney disease - continued	
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	20% coinsurance for Medicare-covered self-dialysis training. *Referral may be required.*
• Home dialysis equipment and supplies	20% coinsurance for Medicare-covered home dialysis equipment. *Prior Authorization may be required.* 20% coinsurance for Medicare-covered dialysis supplies. *Prior Authorization may be required.*
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	20% coinsurance for Medicare-covered home support services. *Referral may be required.*
Skilled nursing facility (SNF) care	
(For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) You are covered for 100 days per admission/per stay. No prior hospital stay is required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary)	For Medicare-covered admissions, per admission: $0 copay per day, for days 1 to 20, $221 copay per day, for days 21 to 40, and a $0 copay per day, for days 41 to 100 for Medicare-covered skilled nursing facility care.

Covered Service	What you pay
Skilled nursing facility (SNF) care - continued • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	You pay all costs for each day after day 100. *Referral may be required.* *Prior Authorization may be required.* Cost shares are applied starting on the first day of admission and do not include the date of discharge.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) - continued • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	and tobacco use cessation preventive benefits.
Social support platform Our plan provides an online social support platform to help support your overall well-being. The platform offers therapeutic activities, community engagement, and plan-sponsored resources to help manage stress and anxiety. The platform makes it easy for you to participate and remain involved to assist you in managing your behavioral health needs. It is available online 24/7, so you can use it whenever you choose. The social support platform includes: • Tailored Well-Being Programs: Access customized 4-week self-guided programs designed to enhance physical and emotional well-being, incorporating insights from healthy aging experts to specifically support members. Follow programs at your own pace and track your progress to monitor improvements in your health. • Peer and Expert Support: Connect with an online community in a moderated space where you can interact with peers and qualified health experts. Obtain access to clinically reviewed articles and receive personalized recommendations for additional Wellcare services based on your interactions and identified needs. • Personalized Digital Health Tools: Engage in interactive activities, meditations, and games grounded in cognitive behavioral therapy, mindfulness, and positive psychology.	$0 copay for the social support platform.*

Covered Service	What you pay
Social support platform - continued These tools address topics such as healthy aging, managing isolation, caregiving, grief, finding purpose in aging, and more. Members can access the platform by logging into their member portal at go.wellcare.com/member or by calling Member Services. After you register, you can access the platform directly at any time from a computer, tablet, or smartphone.	
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$30 copay for each Medicare-covered supervised exercise therapy visit. *Referral may be required.*

Covered Service	What you pay
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.	$25 copay for Medicare-covered urgently needed service visits. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.
Urgently needed services outside the United States are covered.	$150 copay for urgently needed services outside of the United States.* You pay this amount even if you are admitted to the hospital for the same condition. You are covered for up to $50,000 every year for emergency or urgently needed services outside the United States.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts	$10 copay for all other eye exams to diagnose and treat diseases of the eye. *Prior Authorization may be required.*

Covered Service	What you pay
Vision care - continued	
• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older	$0 copay for a Medicare-covered glaucoma screening. *Referral may be required.*
• For people with diabetes, screening for diabetic retinopathy is covered once per year	$0 copay for Medicare-covered retinal exam for diabetic members or diabetic eye exam. *Prior Authorization may be required.*
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery	$0 copay for Medicare-covered eyewear.
In addition, our plan covers the following supplemental (i.e., routine) vision services:	
• Routine eye exam 1 routine eye exam every year. The routine eye exam includes a glaucoma test for people who are at risk for glaucoma and a retinal exam for diabetics.	$0 copay for 1 routine eye exam every year.* *Prior Authorization may be required.*
• Eyewear fitting Limited to 1 visit(s) every year. The visit for eyewear fitting is not a routine eye exam. Services include fitting of eyewear (contact lenses, eyeglass frames/lenses).	$0 copay for 1 eyewear fitting visit every year.* *Prior Authorization may be required.*
• Eyewear Unlimited pairs of prescription eyewear every year up to a maximum benefit of $300 every year. Covered eyewear includes any of the following: ○ Eyeglasses (frame and lenses) or	$0 copay for eyewear.* *Prior Authorization may be required.*

Covered Service	What you pay
Vision care - continued ○ Eyeglass lenses only or ○ Eyeglass frames only or ○ Contact lenses instead of eyeglasses or ○ Vision hardware upgrades **Note:** Contact lenses fitting fee is covered by the plan. Maximum plan benefit coverage amount of $300 every year applies to the retail cost of frames and/or lenses (including any lens options such as tints and coatings). You are responsible for any costs above the benefit maximum for supplemental (i.e., routine) eyewear.* Medicare-covered eyewear is not included in the supplemental (i.e., routine) benefit maximum. Members cannot use their supplemental eyewear benefit to increase their coverage on Medicare-covered eyewear. Vision services must be obtained through the plan's vision network. For questions on how to find a provider or for more information call Member Services.	
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (and vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit. • Medicare-covered EKG following the *Welcome to Medicare* Preventive Service.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. $0 copay for each Medicare-covered EKG

Covered Service	What you pay
Welcome to Medicare preventive visit - continued	following the *Welcome to Medicare* Preventive Service. *Referral may be required.*
Wellcare Spendables® You will receive a total of **$50 monthly** preloaded on your Wellcare Spendables® card to spend on OTC items, Dental, Vision, and Hearing services. • Your monthly allowance **rolls over to the following month if unused and expires at the end of the plan year.** **<u>Your card allowance can be used towards</u> -** **Over-the-Counter items (OTC):** You can use your card to purchase over-the-counter (OTC) items at participating retail locations, through the mobile app, or by logging in to your member portal to place an order for home delivery. Covered OTC items include: • Allergy, cold, cough, flu, and sinus products • Pain relief, digestive health, and sleep aid products • Vitamins and supplements • First aid supplies and non-prescription medical supplies • General oral care, eye care, and ear care items • Incontinence supplies, feminine health products, and daily living aids Use your in-app barcode scanner to locate approved items at retail locations, or log into your member portal. **Note:** Under certain circumstances diagnostic equipment and smoking-cessation aids are covered under the plan's medical benefits. You should (when possible) use our plan's medical benefits prior to spending your OTC allowance on these items.	There is no coinsurance, copayment, or deductible for the Wellcare Spendables® card. There is no minimum requirement for in-store purchases.

Covered Service	What you pay
Wellcare Spendables® - continued **Dental, Vision, and Hearing:** You may use your card to help reduce your out-of-pocket expenses for dental, vision, and hearing services. The card may be used at your dental, vision, or hearing provider. • All purchases and transactions must be placed within a provider office or provider location. • The allowance cannot be used for cosmetic or aesthetic services, nitrous oxide, intravenous sedation, teeth whitening, or bleaching. **Your card may be used for the following:** **Dental** • Oral exam • Dental X-ray • Other Diagnostic Dental Services • Prophylaxis (Cleaning) • Fluoride Treatment • Other Preventive Dental Services • Restorative Services • Endodontics • Periodontics • Prosthodontics, removable • Prosthodontics, fixed • Oral and Maxillofacial Surgery • Adjunctive General Services This allowance is not a replacement of your routine dental benefit. You should use our plan's benefit prior to using your Spendables allowance. **Vision** • Routine eye exam • Contact lenses • Eyeglasses (lenses and frames) • Eyeglass lenses • Eyeglass Frames • Upgrades	

Covered Service	What you pay
Wellcare Spendables® - continued This allowance is not a replacement of your routine vision benefit. You should use our plan's benefit prior to using your Spendables allowance. **Hearing** • Routine hearing exam • Fitting/evaluation for hearing aid • Prescription Hearing Aids (all types) This allowance is not a replacement of your routine hearing benefit. You should use our plan's benefit prior to using your Spendables allowance. **How to use your card:** 1. Activate your card before you use it. 2. Visit a participating retailer, log into the portal link listed below, or download the Wellcare Spendables® mobile app. 3. Select your approved items or services. 4. In store, proceed to the retailer's checkout and pay with your Wellcare Spendables® card. For online or mobile app orders, log in to access and use your benefit. 5. Your card is not a credit card but may be entered as "credit" at checkout. If prompted, enter the PIN you created when you activated your card. **Additional information you should know:** • Once you've used your spending allowance, you are responsible for the remaining cost of your purchases. • Items purchased in store may be returned following the retailer's return and exchange policies. Items purchased online are final sale. If an item is damaged or spoiled, please contact us. • If your card is not functioning properly or in the event of a technical issue, please contact us using the number below. • Wellcare is not responsible for lost or stolen cards.	

Covered Service	What you pay
Wellcare Spendables® - continued • The Wellcare Spendables® card is for your personal use only, cannot be sold or transferred, and has no cash value. • Select benefits may be eligible for reimbursement if payment is unsuccessful. Contact us or submit a reimbursement request through the member portal for review. Reimbursement requests must be submitted during the plan year in which the item or service was purchased. Additional information may be required to verify qualifying purchases. • Limitations and restrictions may apply, only approved items are covered. **For more information about the Wellcare Spendables® card or to request a catalog, please call:** 1-800-977-7522, TTY users 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. **You can also visit online at:** go.wellcare.com/member.	

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	See the 'Meals' benefit in the Medical Benefits Chart for more information

Services not covered by Medicare	Covered only under specific conditions
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as: • **Orthodontic services** • **Implant services** • **Maxillofacial prosthetics**	Not covered under any condition See the Dental care services benefit in the Medical Benefits Chart for routine dental care your plan covers as part of your benefit package
Routine foot care (podiatry)	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)

Services not covered by Medicare	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Vision Care: Radial keratotomy, LASIK surgery, and other low vision aids	Not covered under any condition
Vision Care: Routine eye examinations, eyeglasses	See the Vision care benefit in the Medical Benefits Chart for routine vision services your plan covers as part of your benefit package.

CHAPTER 5:

Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing as discussed in this material. First try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you've got emergency or urgently needed medical care from a provider who's not in our plan's network**

   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.

- If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records.

You must submit your claim to us within 365 days of the date you got the service or item.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster. For Member Reimbursements, we do have claim forms available via the web portal. While we strongly recommend that our members use the form, to ensure all documentation is submitted, it is not necessary. They can also submit a copy of the bill without the form. Either way they should include the provider information, dates of service, Current Procedural Terminology (CPT) codes when applicable, diagnosis codes or descriptions and billed amounts along with any medical records available to them and if necessary, a brief description of why they required care. The member should also submit proof of payment at the same time they submit the claim. Valid proof of payment is bank or credit card statements or copy of canceled check.
- Download a copy of the form from our website (go.wellcare.com/TX) or call Member Services at 1-800-977-7522 (TTY users call 711) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Payment Request Address
Member Reimbursement Dept
Medical Reimbursement Department
PO Box 10420
Van Nuys, CA 91410-0420

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with

detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, audio, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan can meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including Spanish and audio, in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-977-7522 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Sección 1.1 Debemos proporcionar la información de una manera que se adapte a usted y a sus sensibilidades culturales (en idiomas distintos del inglés, en audio, en braille, en letra grande o en otros formatos alternativos, etc.)

Nuestro plan está obligado a garantizar que todos los servicios, tanto clínicos como no clínicos, se proporcionen de manera competente desde el punto de vista cultural y sean accesibles para todos los afiliados, incluidos los que tienen un nivel de inglés o una capacidad de lectura limitados, una incapacidad auditiva o un origen cultural y étnico diverso. Algunos ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad son proporcionar servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo), entre otros.

Nuestro plan cuenta con servicios de interpretación gratuitos para responder a las preguntas de los afiliados que no hablan inglés. También podemos proporcionarle información en idiomas distintos del inglés, incluidos español y en formatos de audio, braille, letra grande u otros formatos alternativos, sin costo, si los necesita. Estamos obligados a ofrecerle información sobre los beneficios de nuestro plan en un formato accesible y adecuado para usted. Para recibir información de nuestra parte en un formato que se ajuste a sus necesidades, comuníquese con Servicios para Miembros al 1-800-977-7522 (usuarios de TTY pueden llamar al 711).

Nuestro plan está obligado a ofrecer a las mujeres afiliadas la opción de acceder directamente a un especialista en salud femenina dentro de la red para los servicios de atención médica de rutina y preventiva para mujeres.

Si no hay proveedores disponibles dentro de la red de nuestro plan para una especialidad, es responsabilidad de nuestro plan localizar proveedores especializados fuera de la red que le proporcionen la atención médica necesaria. En este caso, solo pagará la distribución de costos dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red de nuestro plan que cubran un servicio que usted necesita, llame a nuestro plan para que le informen dónde acudir a fin de recibir este servicio con la distribución de costos dentro de la red.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, para atenderse con un especialista en salud femenina o encontrar un especialista de la red, llame a fin de presentar una queja a Servicios para Miembros. También puede presentar un reclamo ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Office for Civil Rights al 1-800-368-1019 o al TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice,* that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-800-977-7522 (TTY users call 711).

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-800-977-7522 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
  - You may ask Member Services for more information about our network providers, including their qualifications, medical school attended, residency completion, and board certification. Both Member Services and the website can give you the most up-to-date information about changes in our network providers. This information can be found on our website at go.wellcare.com/2027providerdirectories.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
  - **Note:** Our plan does not reward practitioners, providers, or employees who perform utilization reviews, including those of delegated entities. Utilization Management (UM) decision making is based only on appropriateness of care and service, and existence of coverage. Additionally, the plan does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand.*

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance in these situations are called **advance directives.** Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people**. Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask whether you signed an advance directive form and whether you have it with you.

- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with TX Health and Human Services at 1-512-424-6500. TTY users should call 1-512-424-6597, or visit https://www.hhs.texas.gov/formas/advance-directives.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly.**

Section 1.7 You have the right to make recommendations about our member rights and responsibilities policy

If you have any questions or concerns about the rights and responsibilities or if you have suggestions to improve our member rights policy, share your thoughts with us by contacting Member Services.

Section 1.8 Evaluation of new technologies

New technologies include procedures, drugs, biological products, or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, biological products, and devices. Our plan follows Medicare's National and Local Coverage Determinations when applicable.

In the absence of a Medicare coverage determination, our plan assesses new technology or new applications of existing technologies for inclusion in applicable benefits plans to ensure members have access to safe and effective care by performing a critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, diagnostic test studies with statistically significant results that demonstrate safety and effectiveness and review of evidence based guidelines developed by national organizations and recognized authorities. Our plan also considers opinions, recommendations and assessments by practicing physicians, nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology

assessment organizations, reports and publications of government agencies (for example, the Food and Drug Administration (FDA), Centers for Disease Control (CDC), and National Institutes of Health (NIH)).

Section 1.9 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services at 1-800-977-7522 (TTY users call 711)**
- **Call your local SHIP** at 1-800-252-9240.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.10 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-800-977-7522 (TTY users call 711)**
- **Call your local SHIP** at 1-800-252-9240.
- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections*. (available at: Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-800-977-7522 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.

- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand. You have the responsibility to understand your health problems and help set treatment goals that you and your doctor agree upon.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you're responsible for these payments:
  - You must continue to pay your premium for your Medicare Part B to stay a member of our plan.
  - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-800-977-7522 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand

which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free.

Texas Department of Aging and Disability Services (HICAP)
1-800-252-9240, TTY users call: 1-800-735-2989
8:00 a.m. - 5:00 p.m. local time, Monday - Friday

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- Visit Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at 1-800-977-7522 (TTY users call 711)**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-800-977-7522 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at go.wellcare.com/TX.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your** behalf. You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Member Services at 1-800-977-7522 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at go.wellcare.com/TX.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 7:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure information applies to you, call Member Services at 1-800-977-7522 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**
5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions, we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast Coverage decisions, we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 of this chapter for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.

- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they

take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests,** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-800-977-7522 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 1-800-977-7522 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-977-7522 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-800-977-7522 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call

1-877-486-2048.) Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called *upholding the decision*.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care*.

If you think we're ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to request a fast track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-977-7522 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non*-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage.*
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.

- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage,* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, (for a total of 5 levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4 and 5

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Cour**t will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?

Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at 1-800-977-7522 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the Grievance Procedure.** To make a complaint, or if you have questions about this procedure, please call Member Services. Or you may mail a written request to the address listed under *Complaints about Medical Care* in Chapter 2 of this document.
    - If you ask for a written response, if you file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing.
    - You need to file your complaint within 60 calendar days after the event. You can submit your complaint, formally, in writing at the address under *Complaints about Medical Care* in Chapter 2 of this document.
    - We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
    - In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:
        - We deny your request for a fast review of a request for medical care.

- We deny your request for a fast review of an appeal of denied services.
- We decide additional time is needed to review your request for medical care.
- We decide additional time is needed to review your appeal of denied medical care.

- You may submit this type of complaint by phone by calling Member Services. You may also submit the complaint to us in writing at the address listed under *Complaints about Medical Care* in Chapter 2 of this document. Once we receive the expedited grievance, a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care,* you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Wellcare Patriot Simple (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
  - Another Medicare health plan, with or without drug coverage,
  - Original Medicare *with* a separate Medicare drug plan,
  - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and, for new Medicare enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period,** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Texas Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change your plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership, you can:

- **Call Member Services at 1-800-977-7522 (TTY users call 711**)
- Find the information in the ***Medicare & You 2027*** handbook
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Wellcare Patriot Simple (HMO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Wellcare Patriot Simple (HMO) when your new plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll or visit our website to disenroll online.** Call Member Services at 1-800-977-7522 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Wellcare Patriot Simple (HMO) when your coverage in Original Medicare starts.

Note: If you also have creditable prescription drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services care through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Wellcare Patriot Simple (HMO) must end your plan membership in certain situations

Wellcare Patriot Simple (HMO) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months

- If you move or take a long trip, call Member Services at 1-800-977-7522 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area

- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or national, or eligible noncitizen
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General

If you have questions or want more information on when we can end your membership, call Member Services at 1-800-977-7522 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Wellcare Patriot Simple (HMO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

Our health plan complies with Federal Civil Rights Laws. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Services at 1-800-977-7522 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises

under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Recovery of benefits paid by our plan under your Wellcare Patriot Simple (HMO) plan

When you are injured

If you are ever injured, become ill or develop a condition through the actions of another person, company, or yourself (a "responsible party"), our plan will provide benefits for covered services that you receive. However, if you receive money or are entitled to receive money because of your injury, illness or condition, whether through a settlement, judgment, or any other payment associated with your injury, illness or condition, our plan and/or the treating providers retain the right to recover the value of any services provided to you through this plan in accordance with applicable State law.

As used throughout this provision, the term "responsible party" means any person or entity actually or potentially responsible for your injury, illness or condition. The term responsible party includes the liability or other insurer of the responsible person or entity.

Some examples of how you could be injured, become ill or develop a condition through the actions of a responsible party include, but are not limited to:

- You are in a car accident;
- You slip and fall in a store; or
- You are exposed to a dangerous chemical at work.

Our plan's right of recovery applies to any and all amounts you receive from the responsible party, including but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage or umbrella coverage;
- Any settlement or judgement received from a lawsuit or other legal action; or
- Any other payments from any other source received as compensation for the responsible party's actions or omissions.

By accepting benefits under this plan, you agree that our plan has a first priority right of subrogation and reimbursement that attaches when this plan has paid benefits for Covered Services that you

received due to the actions or omissions of a responsible party, and you or your representative recovers, or is entitled to recover, any amounts from a responsible party.

By accepting benefits under this plan, you also (i) assign to our plan your right to recover medical expenses from any coverage available up to the full cost of all Covered Services provided by the plan in connection with your injury, illness or condition, and (ii) you agree to specifically direct the responsible party to directly reimburse the plan on your behalf.

By accepting benefits under this plan, you also give our plan a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement for the full cost of benefits for Covered Services paid under the plan that are associated with your injury, illness or condition due to the actions or omissions of a responsible party. This priority applies regardless of whether the amounts are specifically identified as a recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss. Our plan may recover the full cost of all benefits provided by this plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No attorney fees may be deducted from our plan's recovery, and our plan is not required to pay or contribute to paying court costs or attorneys' fees for the attorney hired to pursue the claim or lawsuit against any responsible party.

Steps you must take

If you are injured, become ill or develop a condition because of a responsible party, you must cooperate with our plan's and/or the treating provider's efforts to recover its expenses, including:

- Telling our plan or the treating provider, as applicable, the name and address of the responsible party and/or his or her lawyer, if you know it; the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved; and a description of how the injury, illness or condition was caused.
- Completing any paperwork that our plan or the treating provider may reasonably require to assist in enforcing the lien or right of recovery.
- Promptly responding to inquiries from our plan or the treating provider about the status of the case or claim and any settlement discussions.
- Notifying our plan immediately upon you or your lawyer receiving any money from the responsible party(s) or any other source.
- Paying the health care lien or plan recovery amount from any recovery, settlement or judgment, or other source of compensation, including payment of all reimbursement due to our plan for the full cost of benefits paid under the plan that are associated with your injury, illness or condition due to a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Doing nothing to prejudice our plan's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan or any attempts to deny our plan its first priority right of recovery or lien.

- Holding any money that you or your lawyer receive from the responsible party(s), or from any other source, in trust, and reimbursing our plan or the treating provider, as applicable, for the amount of the recovery due to the plan as soon as you are paid and prior to payment of any other potential lien holders or third parties claiming a right to recover.
- You are required to cooperate with us in pursuing such recoveries or over payments.

SECTION 5 Membership card

A membership card issued by our plan under this *Evidence of Coverage* is for identification purposes only. Possession of a membership card does not confer any right to services or other benefits under this *Evidence of Coverage*. To be entitled to services or benefits under this *Evidence of Coverage*, the holder of the card must be eligible for coverage and be enrolled as a member under this *Evidence of Coverage*. Any person receiving services to which he or she is not then entitled under this *Evidence of Coverage* will be responsible for payment for those services. A member must present the plan's membership card, not a Medicare card, at the time of service. Please call Member Services at 1-800-977-7522 (TTY: 711) if you need your membership card replaced.

Note: Any member knowingly permitting abuse or misuse of the membership card may be disenrolled for cause. Our plan is required to report a disenrollment that results from membership card abuse or misuse to the Office of the Inspector General, which may result in criminal prosecution.

SECTION 6 Independent contractors

The relationship between our plan and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of our plan and neither our plan, nor any employee of our plan, is an employee or agent of a participating provider. In no case will our plan be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not our plan, maintain the physician-patient relationship with the Member. Our plan is not a provider of health care.

SECTION 7 Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation to the plan by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by, for example, filing a claim that contains a false or deceptive statement could be guilty of health care plan fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-866-685-8664 (TTY: 711). The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

SECTION 8 Circumstances beyond the plan's control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, state of emergency or other similar events not within the control of our plan, results in our plan's facilities or personnel not being available to provide or arrange for services or benefits under this *Evidence of Coverage*, the plan's obligation to provide such services or benefits shall be limited to the requirement that our plan make a good faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.

CHAPTER 10:

Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Grievance - A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an *outpatient.*

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Group – An association of physicians, including PCPs and specialists, and other health care providers, including hospitals, that contract with the plan to provide services to enrollees. See Chapter 1, Section 3.2.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage

Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Our plan doesn't offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called *coverage decisions* in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine

(non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Wellcare Spendables® card - A debit card, preloaded by the plan that may be used to help pay for items as described in the Medical Benefits Chart.

Wellcare Patriot Simple (HMO) Member Services

Method	Member Services – Contact Information
Call	1-800-977-7522 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. If you leave a voicemail message, please include your name, and telephone number and a team member will return your call within one (1) business day. Member Services 1-800-977-7522 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
Write	Wellcare By Allwell PO Box 10420 Van Nuys, CA 91410-0420
Website	go.wellcare.com/TX

Texas Department of Aging and Disability Services (HICAP)
Texas Department of Aging and Disability Services (HICAP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
Call	1-800-252-9240
TTY	1-800-735-2989 This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.
Write	Texas Department of Aging and Disability Services 701 West 51st Street, MC: W275 Austin, TX 78711-3247
Website	https://www.hhs.texas.gov/services/health/medicare

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