

## 2022 Wellcare Medicare Advantage Plan Information

Thank you for your interest in applying for the Wellcare Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. Wellcare will send out an outbound enrollment verification letter by mail within 15 calendar days from receipt of the enrollment request.

Enrollment Packet – click links below to view the information

Star Rating: [HMO](#) / [PPO](#)

[Download Application](#)

Benefits: [Low Premium Open PPO \(North\)](#) / [Giveback, Patriot & Premium Ultra \(PPO\)](#)

[Providers](#)

[Formulary](#)

[Pharmacy Locator](#)

### Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15<sup>th</sup> to December 7<sup>th</sup>. This will give you a January 1<sup>st</sup> effective date for your new plan.

### Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15<sup>th</sup> and December 7<sup>th</sup>. ***If they are signed prior to October 15<sup>th</sup> they will be returned to you with a new application.*** If they are received after December 7<sup>th</sup>, you will not be able to change plans until the next AEP for January of the following year.

### Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc...

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC  
PO Box 26540  
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470  
Secure File Upload: [Click here](#)  
Email: [cs@cda-insurance.com](mailto:cs@cda-insurance.com)

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: <https://medicare-washington.com/>

Y0062\_MULTIPLAN\_CDA INSURANCE Washington 2022 (Pending)



# 2022 Summary of Benefits

Oregon and Washington

**Wellcare Giveback Open (PPO)**

H5439 | 015

**Wellcare Premium Ultra Open (PPO)**

H5439 | 011

**Wellcare Patriot No Premium Open (PPO)**

H5439 | 010

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

This is a summary of drug and health services covered by Wellcare Giveback Open (PPO), Wellcare Premium Ultra Open (PPO), and Wellcare Patriot No Premium Open (PPO) from January 1, 2022 to December 31, 2022.

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

**Who can join?**

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

**Our plans and service areas:****H5439015000 Wellcare Giveback Open (PPO) includes:**

- these counties in Oregon: Benton, Clackamas, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill
- Clark county in Washington

**H5439011000 Wellcare Premium Ultra Open (PPO) includes:**

- these counties in Oregon: Benton, Clackamas, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill
- Clark county in Washington

**H5439010000 Wellcare Patriot No Premium Open (PPO) includes:**

- these counties in Oregon: Benton, Clackamas, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill
- Clark county in Washington

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

**Preferred Provider Organizations (PPOs)** You'll enjoy the freedom and flexibility to access your health care where you want it and when you want it. You may seek care from any Medicare provider in the country who agrees to see you as a Medicare member, but you'll generally pay less when you use contracted providers in our network. Out-of-network providers may choose not to bill our plan and may ask you to pay for services up front. If this happens, you can fill out a claim form and submit it to us with a copy of the bill and any documentation you have about payments you have made.

Out-of-network/non-contracted providers are under no obligation to treat Wellcare Giveback Open (PPO), Wellcare Premium Ultra Open (PPO), Wellcare Patriot No Premium Open (PPO) plan members, except in

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emergency situations. Please call our member services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

Which doctors, hospitals and pharmacies can I use? Wellcare Giveback Open (PPO), Wellcare Premium Ultra Open (PPO) and Wellcare Patriot No Premium Open (PPO) have a network of doctors, hospitals, pharmacies, and other providers. You can save money by using our preferred mail-order pharmacy and by using providers in the plan's network. With some plans if you use providers that are not in our network, your share of the costs for covered services may be higher.

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

For more information, please call us at 1-866-277-6583 (TTY users should call 711). Hours are Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. Visit us at [www.wellcare.com/healthnetOR](http://www.wellcare.com/healthnetOR).

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Service Area</b>	<p><b>Our plans and service areas:</b></p> <p><b>H5439015000 Wellcare Giveback Open (PPO) includes:</b></p> <ul style="list-style-type: none"> <li>these counties in Oregon: Benton, Clackamas, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill</li> <li>Clark county in Washington</li> </ul> <p><b>H5439011000 Wellcare Premium Ultra Open (PPO) includes:</b></p> <ul style="list-style-type: none"> <li>these counties in Oregon: Benton, Clackamas, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill</li> <li>Clark county in Washington</li> </ul> <p><b>H5439010000 Wellcare Patriot No Premium Open (PPO) includes:</b></p> <ul style="list-style-type: none"> <li>these counties in Oregon: Benton, Clackamas, Douglas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill</li> <li>Clark county in Washington</li> </ul>		
<b>PPO plans do not require a prior authorization or referral for out-of-network services.</b>			
<b>Monthly plan premium</b> You must continue to pay your Medicare Part B premium.	\$0	\$121	\$0
<b>Part B Premium Reduction</b>	This plan offers a \$29 give back every month in your Social Security check.	Not available	Not available

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Deductible</b>	\$200 deductible for covered medical services	\$145 deductible for covered medical services	\$125 deductible for covered medical services
<b>Maximum out-of-Pocket Responsibility</b> (does not include prescription drugs)	\$7,550 in-network annually \$7,550 combined in and out-of-network annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.	\$4,000 in-network annually \$4,000 combined in and out-of-network annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.	\$2,500 in-network annually \$5,100 combined in and out-of-network annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Inpatient Hospital coverage</b>	<p><b>In-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$450 copay per day for days 1 through 4</li> <li>• \$0 copay per day for days 5 through 90</li> <li>• \$0 copay per day for days 91 and beyond</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$500 copay per day for days 1 through 10</li> <li>• \$0 copay per day for days 11 and beyond</li> </ul>	<p><b>In-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$225 copay per day for days 1 through 7</li> <li>• \$0 copay per day for days 8 through 90</li> <li>• \$0 copay per day for days 91 and beyond</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$250 copay per day for days 1 through 7</li> <li>• \$0 copay per day for days 8 and beyond</li> </ul>	<p><b>In-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$175 copay per day for days 1 through 8</li> <li>• \$0 copay per day for days 9 through 90</li> <li>• \$0 copay per day for days 91 and beyond</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$200 copay per day for days 1 through 8</li> <li>• \$0 copay per day for days 9 and beyond</li> </ul>

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Outpatient Hospital coverage</b> Outpatient hospital services	<b>In-Network</b> \$400 copay for surgical and non-surgical services *  <b>Out-of-Network</b> \$500 copay for surgical and non-surgical services	<b>In-Network</b> \$225 copay for surgical and non-surgical services *  <b>Out-of-Network</b> \$250 copay for surgical and non-surgical services	<b>In-Network</b> \$225 copay for surgical and non-surgical services *  <b>Out-of-Network</b> \$250 copay for surgical and non-surgical services
Outpatient hospital observation services	<b>In-Network</b> \$90 copay for outpatient observation services when you enter observation status through an emergency room. \$400 copay for outpatient observation services when you enter observation status through an outpatient facility. *  <b>Out-of-Network</b> \$500 copay	<b>In-Network</b> \$90 copay for outpatient observation services when you enter observation status through an emergency room. \$225 copay for outpatient observation services when you enter observation status through an outpatient facility. *  <b>Out-of-Network</b> \$250 copay	<b>In-Network</b> \$120 copay per stay for outpatient observation services when you enter observation status through an emergency room. \$225 copay for outpatient observation services when you enter observation status through an outpatient facility. *  <b>Out-of-Network</b> \$200 - \$250 copay

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Ambulatory surgical center (ASC)</b>	<b>In-Network</b> \$250 copay *	<b>In-Network</b> \$200 copay *	<b>In-Network</b> \$150 copay *
	<b>Out-of-Network</b> \$450 copay	<b>Out-of-Network</b> \$250 copay	<b>Out-of-Network</b> \$175 copay
<b>Doctor Visits</b> Primary Care Providers	<b>In-Network</b> \$20 copay	<b>In-Network</b> \$12 copay	<b>In-Network</b> \$12 copay
	<b>Out-of-Network</b> \$30 copay	<b>Out-of-Network</b> \$20 copay	<b>Out-of-Network</b> \$20 copay
Specialists	<b>In-Network</b> \$50 copay	<b>In-Network</b> \$25 copay	<b>In-Network</b> \$25 copay
	<b>Out-of-Network</b> \$60 copay	<b>Out-of-Network</b> \$40 copay	<b>Out-of-Network</b> \$40 copay
<b>Preventive Care</b> (e.g., Annual Wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular screenings, Cervical and vaginal cancer screening, Colorectal cancer screenings, Diabetes screenings, Hepatitis B Virus Screening, Prostate cancer screenings (PSA), Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots))	<b>In-Network</b> \$0 copay	<b>In-Network</b> \$0 copay	<b>In-Network</b> \$0 copay
	<b>Out-of-Network</b> \$0 copay	<b>Out-of-Network</b> \$0 copay	<b>Out-of-Network</b> \$0 copay

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	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Emergency care</b>	\$90 copay Copay is waived if you are admitted to a hospital within 24 hours.	\$90 copay Copay is waived if you are admitted to a hospital within 24 hours.	\$120 copay Copay is waived if you are admitted to a hospital within 24 hours.
Worldwide emergency coverage	\$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.	\$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.	\$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.
<b>Urgently needed services</b>	\$35 copay Copay is waived if you are admitted to a hospital within 24 hours.	\$35 copay Copay is waived if you are admitted to a hospital within 24 hours.	\$25 copay Copay is waived if you are admitted to a hospital within 24 hours.

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**Benefits**

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Worldwide urgent care coverage	\$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.	\$90 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.	\$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.
<b>Diagnostic Services/Labs/Imaging</b>	COVID-19 testing and specified testing-related services at any location are \$0.	COVID-19 testing and specified testing-related services at any location are \$0.	COVID-19 testing and specified testing-related services at any location are \$0.
Lab services	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$20 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$20 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$0 copay
Diagnostic tests and procedures	<b>In-Network</b> \$0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. \$0 copay for the removal of abnormal tissue	<b>In-Network</b> \$0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. \$0 copay for the removal of abnormal tissue	<b>In-Network</b> \$0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. \$0 copay for the removal of abnormal tissue

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
	<p>and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. 20% coinsurance for all other Medicare-covered diagnostic procedures and tests. *</p> <p><b>Out-of-Network</b> \$0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. \$0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. 20% coinsurance for all other Medicare-covered diagnostic procedures and tests.</p>	<p>and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. 17% coinsurance for all other Medicare-covered diagnostic procedures and tests. *</p> <p><b>Out-of-Network</b> \$0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. \$0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. 20% coinsurance for all other Medicare-covered diagnostic procedures and tests.</p>	<p>and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. 15% coinsurance for all other Medicare-covered diagnostic procedures and tests. *</p> <p><b>Out-of-Network</b> \$0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. \$0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. 20% coinsurance for all other Medicare-covered diagnostic procedures and tests.</p>

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
Outpatient X-rays	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$20 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$20 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$20 copay
Diagnostic radiology services (e.g. MRI, CAT Scan)	<b>In-Network</b> \$0 copay for a DEXA scan. \$0 copay for a Diagnostic Mammogram. \$225 copay for diagnostic radiology services at all other locations. \$400 copay for diagnostic radiology services received in an outpatient setting. *  <b>Out-of-Network</b> 20% coinsurance	<b>In-Network</b> \$0 copay for a DEXA scan. \$0 copay for a Diagnostic Mammogram. \$125 copay for diagnostic radiology services at all other locations. \$225 copay for diagnostic radiology services received in an outpatient setting. *  <b>Out-of-Network</b> 30% coinsurance	<b>In-Network</b> \$0 copay for a DEXA scan. \$0 copay for a Diagnostic Mammogram. \$125 copay for diagnostic radiology services at all other locations. \$225 copay for diagnostic radiology services received in an outpatient setting. *  <b>Out-of-Network</b> 20% coinsurance
Therapeutic Radiology	<b>In-Network</b> 20% coinsurance *  <b>Out-of-Network</b> 20% coinsurance	<b>In-Network</b> 20% coinsurance *  <b>Out-of-Network</b> 30% coinsurance	<b>In-Network</b> 20% coinsurance *  <b>Out-of-Network</b> 20% coinsurance

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Hearing services</b> Hearing Exam Medicare Covered	<b>In-Network</b> \$50 copay *	<b>In-Network</b> \$25 copay *	<b>In-Network</b> \$25 copay *
	<b>Out-of-Network</b> \$60 copay	<b>Out-of-Network</b> \$40 copay	<b>Out-of-Network</b> \$40 copay
Routine hearing exam	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *
	<b>Out-of-Network</b> 40% coinsurance	<b>Out-of-Network</b> 40% coinsurance	<b>Out-of-Network</b> 40% coinsurance
	1 exam every year	1 exam every year	1 exam every year
Hearing Aids Hearing Aid Fitting/Evaluation(s)	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *
	<b>Out-of-Network</b> 40% coinsurance	<b>Out-of-Network</b> 40% coinsurance	<b>Out-of-Network</b> 40% coinsurance
	1 fitting(s) / evaluation(s) every year	1 fitting(s) / evaluation(s) every year	1 fitting(s) / evaluation(s) every year

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<p>Hearing aid allowance</p> <p>All types</p>	<p>Up to a \$1,500 allowance for both ears combined every year for hearing aids.</p> <p><b>In-Network</b> \$0 copay *</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p>Limited to 2 hearing aid(s) every year</p>	<p>Up to a \$1,500 allowance for both ears combined every year for hearing aids.</p> <p><b>In-Network</b> \$0 copay *</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p>Limited to 2 hearing aid(s) every year</p>	<p>Up to a \$2,000 allowance for both ears combined every year for hearing aids.</p> <p><b>In-Network</b> \$0 copay *</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p>Limited to 2 hearing aid(s) every year</p>
<p>Additional Hearing Information</p>	<p><b>What you should know</b> Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.</p>	<p><b>What you should know</b> Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.</p>	<p><b>What you should know</b> Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.</p>

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**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Dental services</b>			
Preventive services	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *
	<b>Out-of-Network</b> 50% coinsurance	<b>Out-of-Network</b> 70% coinsurance	<b>Out-of-Network</b> 70% coinsurance
	Cleanings 2 every year	Cleanings 2 every year	Cleanings 2 every year
	Dental x-rays 1 every 12 to 36 months	Dental x-rays 1 every 12 to 36 months	Dental x-rays 1 every 12 to 36 months
	Oral exams 2 every year	Oral exams 2 every year	Oral exams 2 every year
Fluoride Treatment	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *
	<b>Out-of-Network</b> 50% coinsurance	<b>Out-of-Network</b> 70% coinsurance	<b>Out-of-Network</b> 70% coinsurance
	1 every year	1 every year	1 every year

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**Benefits**

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Comprehensive services Medicare Covered	<b>In-Network</b> \$50 copay for each Medicare-covered service. *	<b>In-Network</b> \$25 copay for each Medicare-covered service. *	<b>In-Network</b> \$25 copay for each Medicare-covered service. *
Diagnostic Services	<b>Out-of-Network</b> \$60 copay for each Medicare-covered service.  <b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> 50% coinsurance  1 diagnostic service(s) every year	<b>Out-of-Network</b> \$40 copay for each Medicare-covered service.  <b>In-Network</b> 40% coinsurance *  <b>Out-of-Network</b> 70% coinsurance  1 diagnostic service(s) every year	<b>Out-of-Network</b> \$40 copay for each Medicare-covered service.  <b>In-Network</b> 40% coinsurance *  <b>Out-of-Network</b> 70% coinsurance  1 diagnostic service(s) every year
Restorative Services	<b>In-Network</b> <u>Not covered</u>  <b>Out-of-Network</b> <u>Not covered</u>	<b>In-Network</b> 40% coinsurance *  <b>Out-of-Network</b> 70% coinsurance  1 restorative service(s) every 12 to 84 months.	<b>In-Network</b> 40% coinsurance *  <b>Out-of-Network</b> 70% coinsurance  1 restorative service(s) every 12 to 84 months

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
Endodontics/ Periodontics/ Extractions	<b>In-Network</b> <u>Not covered</u>	<b>In-Network</b> 40% coinsurance *	<b>In-Network</b> 40% coinsurance *
	<b>Out-of-Network</b> <u>Not covered</u>	<b>Out-of-Network</b> 70% coinsurance  1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months 1 extraction(s) per tooth	<b>Out-of-Network</b> 70% coinsurance  1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months 1 extraction(s) per tooth
Non-routine services	<b>In-Network</b> \$0 copay *	<b>In-Network</b> 40% coinsurance *	<b>In-Network</b> 40% coinsurance *
	<b>Out-of-Network</b> 50% coinsurance  1 non-routine service(s) every day to 24 months	<b>Out-of-Network</b> 70% coinsurance  1 non-routine service(s) every day to 24 months	<b>Out-of-Network</b> 70% coinsurance  1 non-routine service(s) every day to 24 months

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	<p><b>In-Network</b> <u>Not covered</u></p> <p><b>Out-of-Network</b> <u>Not covered</u></p>	<p><b>In-Network</b> 40% coinsurance *</p> <p><b>Out-of-Network</b> 70% coinsurance</p> <p>1 Prosthodontic procedure every 12 to 84 months 1 Oral Maxillofacial procedure every 12 to 60 months or per lifetime</p>	<p><b>In-Network</b> 40% coinsurance *</p> <p><b>Out-of-Network</b> 70% coinsurance</p> <p>1 Prosthodontic procedure every 12 to 84 months 1 Oral Maxillofacial procedure every 12 to 60 months or per lifetime</p>
Additional Dental Information	<p><b>What you should know:</b> This plan includes coverage of preventive and comprehensive services up to \$750.</p>	<p><b>What you should know:</b> This plan includes coverage of preventive and comprehensive services up to \$2,000.</p>	<p><b>What you should know:</b> This plan includes coverage of preventive and comprehensive services up to \$2,000.</p>

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Vision Services</b> Eye Exam Medicare Covered	<p><b>In-Network</b> \$0 copay (Medicare-covered diabetic retinopathy screening) \$50 copay (all other Medicare-covered eye exams) *</p> <p><b>Out-of-Network</b> \$0 copay (Medicare-covered diabetic retinopathy screening) \$60 copay (all other Medicare-covered eye exams)</p>	<p><b>In-Network</b> \$0 copay (Medicare-covered diabetic retinopathy screening) \$25 copay (all other Medicare-covered eye exams) *</p> <p><b>Out-of-Network</b> \$0 copay (Medicare-covered diabetic retinopathy screening) \$40 copay (all other Medicare-covered eye exams)</p>	<p><b>In-Network</b> \$0 copay (Medicare-covered diabetic retinopathy screening) \$25 copay (all other Medicare-covered eye exams) *</p> <p><b>Out-of-Network</b> \$0 copay (Medicare-covered diabetic retinopathy screening) \$40 copay (all other Medicare-covered eye exams)</p>
Routine eye exam (Refraction)	<p><b>In-Network</b> \$0 copay *</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p>1 exam every year</p>	<p><b>In-Network</b> \$0 copay *</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p>1 exam every year</p>	<p><b>In-Network</b> \$0 copay *</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p>1 exam every year</p>

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
Glaucoma screening	<b>In-Network</b> \$0 copay for each Medicare-covered service.  <b>Out-of-Network</b> \$0 copay for each Medicare-covered service.	<b>In-Network</b> \$0 copay for each Medicare-covered service.  <b>Out-of-Network</b> \$0 copay for each Medicare-covered service.	<b>In-Network</b> \$0 copay for each Medicare-covered service.  <b>Out-of-Network</b> \$0 copay for each Medicare-covered service.
Eyewear Medicare Covered	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$60 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$0 - \$295 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$40 copay
Routine eyewear  Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames         Eyewear allowance	<b>In-Network</b> \$0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year *  <b>Out-of-Network</b> 40% coinsurance  Up to a \$200 combined allowance every year.	<b>In-Network</b> \$0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year *  <b>Out-of-Network</b> 40% coinsurance  Up to a \$200 combined allowance every year	<b>In-Network</b> \$0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year *  <b>Out-of-Network</b> 40% coinsurance  Up to a \$200 combined allowance every year

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Mental Health Services</b>			
Inpatient visit	<p><b>In-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$350 copay per day for days 1 through 4</li> <li>• \$0 copay per day for days 5 through 90</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$475 copay per day for days 1 through 10</li> <li>• \$0 copay per day for days 11 through 90</li> </ul>	<p><b>In-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$225 copay per day for days 1 through 7</li> <li>• \$0 copay per day for days 8 through 90</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$250 copay per day for days 1 through 7</li> <li>• \$0 copay per day for days 8 through 90</li> </ul>	<p><b>In-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$175 copay per day for days 1 through 8</li> <li>• \$0 copay per day for days 9 through 90</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each admission, you pay:</p> <ul style="list-style-type: none"> <li>• \$200 copay per day for days 1 through 8</li> <li>• \$0 copay per day for days 9 through 90</li> </ul>
Outpatient individual therapy visit	<p><b>In-Network</b> \$25 copay</p> <p><b>Out-of-Network</b> \$50 copay</p>	<p><b>In-Network</b> \$25 copay</p> <p><b>Out-of-Network</b> \$40 copay</p>	<p><b>In-Network</b> \$25 copay</p> <p><b>Out-of-Network</b> \$40 copay</p>
Outpatient group therapy visit	<p><b>In-Network</b> \$25 copay</p> <p><b>Out-of-Network</b> \$50 copay</p>	<p><b>In-Network</b> \$25 copay</p> <p><b>Out-of-Network</b> \$40 copay</p>	<p><b>In-Network</b> \$25 copay</p> <p><b>Out-of-Network</b> \$40 copay</p>

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Skilled nursing facility (SNF)</b>	<p><b>In-Network</b> For each benefit period, you pay:</p> <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$160 copay per day for days 21 through 100</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each benefit period, you pay:</p> <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$195 copay per day for days 21 through 100</li> </ul>	<p><b>In-Network</b> For each benefit period, you pay:</p> <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$184 copay per day for days 21 through 100</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each benefit period, you pay:</p> <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$220 copay per day for days 21 through 100</li> </ul>	<p><b>In-Network</b> For each benefit period, you pay:</p> <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$184 copay per day for days 21 through 100</li> </ul> <p>*</p> <p><b>Out-of-Network</b> For each benefit period, you pay:</p> <ul style="list-style-type: none"> <li>• \$0 copay per day for days 1 through 20</li> <li>• \$220 copay per day for days 21 through 100</li> </ul>
<p><b>Therapy and Rehabilitation Services</b></p> <p>Physical Therapy</p>	<p><b>In-Network</b> \$40 copay</p> <p>*</p> <p><b>Out-of-Network</b> \$50 copay</p>	<p><b>In-Network</b> \$25 copay</p> <p>*</p> <p><b>Out-of-Network</b> \$40 copay</p>	<p><b>In-Network</b> \$25 copay</p> <p>*</p> <p><b>Out-of-Network</b> \$40 copay</p>

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

**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
Outpatient rehabilitation services provided by an occupational therapist	<b>In-Network</b> \$40 copay *	<b>In-Network</b> \$25 copay *	<b>In-Network</b> \$25 copay *
	<b>Out-of-Network</b> \$50 copay	<b>Out-of-Network</b> \$40 copay	<b>Out-of-Network</b> \$40 copay
Pulmonary rehabilitation services	<b>In-Network</b> \$30 copay	<b>In-Network</b> \$25 copay	<b>In-Network</b> \$25 copay
	<b>Out-of-Network</b> \$50 copay	<b>Out-of-Network</b> \$40 copay	<b>Out-of-Network</b> \$40 copay
<b>Ambulance</b> Ground Ambulance	<b>In-Network</b> \$300 copay *	<b>In-Network</b> \$295 copay *	<b>In-Network</b> \$100 copay *
	<b>Out-of-Network</b> \$300 copay	<b>Out-of-Network</b> \$295 copay	<b>Out-of-Network</b> \$100 copay
Air Ambulance	<b>In-Network</b> \$300 copay *	<b>In-Network</b> \$295 copay *	<b>In-Network</b> \$100 copay *
	<b>Out-of-Network</b> \$300 copay	<b>Out-of-Network</b> \$295 copay	<b>Out-of-Network</b> \$100 copay
<b>Transportation Services</b>	<b>In-Network</b> <u>Not covered</u>	<b>In-Network</b> <u>Not covered</u>	<b>In-Network</b> <u>Not covered</u>
	<b>Out-of-Network</b> <u>Not covered</u>	<b>Out-of-Network</b> <u>Not covered</u>	<b>Out-of-Network</b> <u>Not covered</u>

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



**Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Medicare Part B Drugs</b> Chemotherapy drugs	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *
	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 30% coinsurance
Other Part B drugs	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *
	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 30% coinsurance

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

Prescription Drug Coverage	Wellcare Giveback Open (PPO) H5439, Plan 015	Wellcare Premium Ultra Open (PPO) H5439, Plan 011	Wellcare Patriot No Premium Open (PPO) H5439, Plan 010		
<b>Stage 1: Annual Prescription Deductible</b>					
<b>Deductible</b>	\$200 for Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) Part D prescription drugs. For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately.	\$95 for Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) Part D prescription drugs. For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately.	<u>Not covered</u>		
<b>Stage 2: Initial Coverage (after you pay your deductible, if applicable)</b>					
<p>You pay the following until your total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.</p>					
<b>Retail cost-sharing (30-day/90-day supply)</b>					
	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	<b>Standard</b>
<b>Tier 1</b> (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	\$5 / \$15 copay	\$10 / \$30 copay	\$5 / \$15 copay	\$10 / \$30 copay	<u>Not covered</u>
<b>Tier 2</b> (Generic Drugs - includes generic drugs and may include some brand drugs.)	\$15 / \$45 copay	\$20 / \$60 copay	\$10 / \$30 copay	\$20 / \$60 copay	<u>Not covered</u>

Prescription Drug Coverage	Wellcare Giveback Open (PPO) H5439, Plan 015		Wellcare Premium Ultra Open (PPO) H5439, Plan 011		Wellcare Patriot No Premium Open (PPO) H5439, Plan 010
	Preferred	Standard	Preferred	Standard	Standard
<b>Tier 3</b> (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	\$37 / \$111 copay	\$47 / \$141 copay	\$37 / \$111 copay	\$47 / \$141 copay	<u>Not covered</u>
<b>Tier 4</b> (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	\$90 / \$270 copay	\$100 / \$300 copay	\$90 / \$270 copay	\$100 / \$300 copay	<u>Not covered</u>
<b>Tier 5</b> (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	29% coinsurance / Not Available	29% coinsurance / Not Available	31% coinsurance / Not Available	31% coinsurance / Not Available	<u>Not covered</u>
<b>Tier 6</b> (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay	<u>Not covered</u>

Prescription Drug Coverage	Wellcare Giveback Open (PPO) H5439, Plan 015	Wellcare Premium Ultra Open (PPO) H5439, Plan 011	Wellcare Patriot No Premium Open (PPO) H5439, Plan 010		
<b>Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)</b>					
<b>Mail-order cost-sharing (30-day/90-day supply)</b>					
	Preferred	Standard	Preferred	Standard	Standard
<b>Tier 1</b> (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	\$5 / \$0 copay	\$10 / \$30 copay	\$5 / \$0 copay	\$10 / \$30 copay	<u>Not covered</u>
<b>Tier 2</b> (Generic Drugs - includes generic drugs and may include some brand drugs.)	\$15 / \$0 copay	\$20 / \$60 copay	\$10 / \$0 copay	\$20 / \$60 copay	<u>Not covered</u>
<b>Tier 3</b> (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	\$37 / \$74 copay	\$47 / \$141 copay	\$37 / \$74 copay	\$47 / \$141 copay	<u>Not covered</u>
<b>Tier 4</b> (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	\$90 / \$180 copay	\$100 / \$300 copay	\$90 / \$180 copay	\$100 / \$300 copay	<u>Not covered</u>

Prescription Drug Coverage	Wellcare Giveback Open (PPO) H5439, Plan 015		Wellcare Premium Ultra Open (PPO) H5439, Plan 011		Wellcare Patriot No Premium Open (PPO) H5439, Plan 010
	Preferred	Standard	Preferred	Standard	Standard
<b>Tier 5</b> (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	29% coinsurance / Not Available	29% coinsurance / Not Available	31% coinsurance / Not Available	31% coinsurance / Not Available	<u>Not covered</u>
<b>Tier 6</b> (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay	\$0 / \$0 copay	<u>Not covered</u>
<b>Stage 3: Coverage Gap</b>					
	<p>After your total drug costs (including what our plan has paid and what you have paid) reach \$4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.</p> <p>During this stage, for select drugs on Tier 6 you pay your copayment or coinsurance. Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.</p>		<p>After your total drug costs (including what our plan has paid and what you have paid) reach \$4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.</p> <p>During this stage, for select drugs on Tier 6 you pay your copayment or coinsurance. Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.</p>		<u>Not covered</u>

Prescription Drug Coverage	Wellcare Giveback Open (PPO) H5439, Plan 015		Wellcare Premium Ultra Open (PPO) H5439, Plan 011		Wellcare Patriot No Premium Open (PPO) H5439, Plan 010
	Preferred	Standard	Preferred	Standard	Standard
<b>Stage 4: Catastrophic Coverage</b>					
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of: <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs.</li> </ul>		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of: <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs.</li> </ul>		<u>Not covered</u>

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

**Excluded Drugs:**

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

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

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

**Additional Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Chiropractic Services</b> Medicare-covered	<b>In-Network</b> \$20 copay *  <b>Out-of-Network</b> \$20 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$0 copay	<b>In-Network</b> \$0 copay *  <b>Out-of-Network</b> \$0 copay
Routine chiropractic services	<b>In-Network</b> <u>Not covered</u>  <b>Out-of-Network</b> <u>Not covered</u>	See Complimentary Alternative Medicine benefit below	See Complimentary Alternative Medicine benefit below
<b>Acupuncture</b> Medicare-covered	<b>In-Network</b> \$20 copay for Medicare-covered Acupuncture received in a PCP office. \$50 copay for Medicare-covered Acupuncture received in a Specialist office. \$20 copay for Medicare-covered Acupuncture received in a Chiropractor office. *  <b>Out-of-Network</b> \$30 copay for Medicare-covered Acupuncture received in a PCP	<b>In-Network</b> \$12 copay for Medicare-covered Acupuncture received in a PCP office. \$25 copay for Medicare-covered Acupuncture received in a Specialist office. \$0 copay for Medicare-covered Acupuncture received in a Chiropractor office. *  <b>Out-of-Network</b> \$20 copay for Medicare-covered Acupuncture received in a PCP	<b>In-Network</b> \$12 copay for Medicare-covered Acupuncture received in a PCP office. \$25 copay for Medicare-covered Acupuncture received in a Specialist office. \$0 copay for Medicare-covered Acupuncture received in a Chiropractor office. *  <b>Out-of-Network</b> \$20 copay for Medicare-covered Acupuncture received in a PCP

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

**Additional Benefits**

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
	office. \$60 copay for Medicare-covered Acupuncture received in a Specialist office. \$20 copay for Medicare-covered Acupuncture received in a Chiropractor office.	office. \$40 copay for Medicare-covered Acupuncture received in a Specialist office. \$0 copay for Medicare-covered Acupuncture received in a Chiropractor office.	office. \$40 copay for Medicare-covered Acupuncture received in a Specialist office. \$0 copay for Medicare-covered Acupuncture received in a Chiropractor office.
Routine acupuncture services	<b>In-Network</b> <u>Not covered</u>  <b>Out-of-Network</b> <u>Not covered</u>	See Complimentary Alternative Medicine benefit below	See Complimentary Alternative Medicine benefit below
<b>Podiatry Services (Foot Care)</b> Medicare Covered	<b>In-Network</b> \$50 copay  <b>Out-of-Network</b> \$60 copay  <b>What you should know:</b> Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.	<b>In-Network</b> \$25 copay  <b>Out-of-Network</b> \$40 copay  <b>What you should know:</b> Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.	<b>In-Network</b> \$25 copay  <b>Out-of-Network</b> \$40 copay  <b>What you should know:</b> Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.

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



## Additional Benefits

	<b>Wellcare Giveback Open (PPO) H5439, Plan 015</b>	<b>Wellcare Premium Ultra Open (PPO) H5439, Plan 011</b>	<b>Wellcare Patriot No Premium Open (PPO) H5439, Plan 010</b>
<b>Virtual Visits</b>	<p>Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors via Teladoc to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more.</p> <p>A virtual visit (also known as a telehealth consult) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.</p>		
<b>Home health agency care</b>	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *
	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 20% coinsurance
<b>Medical Equipment/Supplies</b> Durable Medical Equipment (DME)	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *
	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 30% coinsurance	<b>Out-of-Network</b> 30% coinsurance
Prosthetics	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *
	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 30% coinsurance	<b>Out-of-Network</b> 30% coinsurance

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

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Diabetic supplies	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *	<b>In-Network</b> \$0 copay *
	<b>Out-of-Network</b> \$0 copay	<b>Out-of-Network</b> \$0 copay	<b>Out-of-Network</b> \$0 copay
Diabetic therapeutic shoes or inserts	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *	<b>In-Network</b> 20% coinsurance *
	<b>Out-of-Network</b> 20% coinsurance	<b>Out-of-Network</b> 30% coinsurance	<b>Out-of-Network</b> 30% coinsurance
<b>Opioid treatment program services</b>	<b>In-Network</b> \$50 copay	<b>In-Network</b> \$25 copay	<b>In-Network</b> \$25 copay
	<b>Out-of-Network</b> \$60 copay	<b>Out-of-Network</b> \$40 copay	<b>Out-of-Network</b> \$40 copay
<b>Wellness Programs</b>	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.
Fitness	\$0 copay Coverage includes: Activity Tracker and Physical Fitness	\$0 copay Coverage includes: Activity Tracker and Physical Fitness	\$0 copay Coverage includes: Activity Tracker and Physical Fitness

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	<p><b>What you should know:</b></p> <p>This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.</p>	<p><b>What you should know:</b></p> <p>This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.</p>	<p><b>What you should know:</b></p> <p>This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.</p>
Additional sessions of smoking and tobacco cessation counseling	<p><b>In-Network</b> \$0 copay</p> <p><b>Out-of-Network</b> \$0 copay</p> <p>Limited to 5 visit(s) every year</p>	<p><b>In-Network</b> \$0 copay</p> <p><b>Out-of-Network</b> \$0 copay</p> <p>Limited to 5 visit(s) every year</p>	<p><b>In-Network</b> \$0 copay</p> <p><b>Out-of-Network</b> \$0 copay</p> <p>Limited to 5 visit(s) every year</p>

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Additional Routine Annual Physical	<p><b>In-Network</b> \$0 copay</p> <p><b>Out-of-Network</b> \$0 copay <b>What you should know:</b> Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.</p>	<p><b>In-Network</b> \$0 copay</p> <p><b>Out-of-Network</b> \$0 copay <b>What you should know:</b> Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.</p>	<p><b>In-Network</b> \$0 copay</p> <p><b>Out-of-Network</b> \$0 copay <b>What you should know:</b> Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.</p>
24-Hour Nurse Advice Line	\$0 copay	\$0 copay	\$0 copay
<p><b>Special Supplemental Benefits for Chronically Ill (SSBCI)</b> To qualify for these benefits you must meet specific criteria, including having a qualifying chronic condition and determined to be eligible for high-risk care management. For a complete list of eligibility criteria, please see the Evidence of Coverage.</p>	<p>Robotic Companion: You pay \$0 copay Covers an interactive companion cat or dog from a contracted provider. Limitations apply.</p> <p>Referral may be required *</p>	<p>Robotic Companion: You pay \$0 copay Covers an interactive companion cat or dog from a contracted provider. Limitations apply.</p> <p>Referral may be required *</p>	<p>Robotic Companion: You pay \$0 copay Covers an interactive companion cat or dog from a contracted provider. Limitations apply.</p> <p>Referral may be required *</p>

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<b>Complimentary Alternative Medicine</b>	<u>Not covered</u>	<p><b>In-Network</b> \$0 copay for alternative pain treatment therapies.</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p><b>What you should know:</b> This plan provides 24 visits for specialties including naturopathy, routine chiropractor or acupuncture benefits.</p>	<p><b>In-Network</b> \$0 copay for alternative pain treatment therapies.</p> <p><b>Out-of-Network</b> 40% coinsurance</p> <p><b>What you should know:</b> This plan provides 24 visits for specialties including naturopathy, routine chiropractor or acupuncture benefits.</p>

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ATENCIÓN: Si habla español, contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. Llame al número de Servicios para Miembros que se indica para su estado en la página siguiente.

注意：如果您說中文，您可以免費獲得語言援助服務。請撥打針對您所在州列示於下一頁的會員服務部電話號碼。

Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí dành cho quý vị. Hãy gọi số điện thoại của bộ phận Dịch Vụ Thành Viên thuộc bang của quý vị ở trang tiếp theo.

주의사항: 한국어를 구사할 경우, 언어 보조 서비스를 무료로 이용 가능합니다. 다음 페이지에서 가입자의 주에 해당하는 목록 내 가입자 서비스부 번호로 전화해 주십시오.

Atensyon: Kung nagsasalita ka ng Tagalog, may mga available na libheng tulong sa wika para sa iyo. Tumawag sa numero ng Mga Serbisyo para sa Miyembro na nakalista para sa iyong estado sa susunod na page.

Dumngeg: No agsasau ka iti Ilokano, dagiti tulong nga serbisio, a libre, ket available para kaniam. Awagam iti numero dagiti serbisio iti Miembro a nakalista para iti estadom iti sumaruno a panid.

La Silafia: Afai e te tautala i le gagana Samoa, o lo’o avanoa ia te oe ‘au’aunaga fesoasoani i le gagana, e leai se totogi. Vala’au le Member Services numera lisiina mo lou setete i le isi itulau.

Maliu: Ke wala’au Hawai’i ‘oe, loa’a ke kōkua ma ka unuhi ‘ōlelo me ke kākī ‘ole. E kelepona i ka helu kelepona o ka Māhele Kōkua Hoa i hō’ike ‘ia no kou moku’āina ma kēia ‘ao’ao a’e.