2020

Summary of Benefits

North Carolina

WellCare Premier (PPO)

Avery, Buncombe, Caswell, Durham, Haywood, Henderson, Jackson, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

H7175 | Plan 001

WellCare Value (HMO)

Caswell, Durham, Orange, Person, Warren

H0712 | Plan 022

WellCare Value (HMO)

Avery, Buncombe, Haywood, Henderson, Jackson, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, Yancey

H0712 | Plan 023

WellCare®

Beyond Healthcare. A Better You.

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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 Premier (PPO), WellCare Value (HMO), WellCare Value (HMO) from January 1, 2020 to December 31, 2020.

The plans listed in this book are Medicare Advantage plans with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. The plan's Evidence of Coverage provides a complete list of services we cover. The Evidence of Coverage is available on our website or you may call us to request a copy at the number below.

To join one of our plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Our plans and service area:
H7175001000 WellCare Premier (PPO) Avery, Buncombe, Caswell, Durham, Haywood, Henderson, Jackson, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

H0712022000 WellCare Value (HMO) Caswell, Durham, Orange, Person, Warren

H0712023000 WellCare Value (HMO) Avery, Buncombe, Haywood, Henderson, Jackson, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, Yancey

Like all Medicare health plans, our plans also cover everything that Original Medicare covers with additional benefits to support your well-being. This includes our Nurse Advice Line whose on-call nurses are available 24 hours a day to answer questions about your health care needs.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Which doctors, hospitals and pharmacies can I use?
WellCare has a network of doctors, hospitals, pharmacies and other providers. You can save money by using providers in the plan's network.

Which doctors, hospitals and pharmacies can I use?
WellCare Premier (PPO) has a network of doctors, hospitals, pharmacies and other providers. You can save money by using providers in the plan's network. 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 at our website: www.wellcare.com/medicare. Or, call us and we'll send you a copy.

How will I determine my drug costs?
If your plan offers a drug benefit, you will generally have to use one of our network pharmacies to fill your prescriptions covered by Part D. You will need to use our plan's formulary (list of covered drugs) to locate what tier your drug is on to determine how much it will cost you. Each medication will be grouped into one of the five tiers. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the drug benefit stages that occur, if applicable: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-833-444-9088 TTY users should call 711 Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and

September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m., or visit us at www.wellcare.com/medicare.

Summary of Benefits

January 1, 2020 - December 31, 2020

Monthly Premium, Deductible and Limits	**WellCare Premier (PPO)** **H7175001000** **NC**
	Avery, Buncombe, Caswell, Durham, Haywood, Henderson, Jackson, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey
Monthly Plan Premium	**$0.00** **What you should know** You must continue to pay your Medicare Part B premium.
Deductible	**In-Network** No Deductible **What you should know** See the Prescription Drug Benefits section of this document for Part D Prescription Drug Deductible information.
Maximum Out-of-Pocket Responsibility (MOOP) (does not include prescription drugs)	**In-Network** **$5,500** annually **Combined and/or Out-of-Network** **$10,000** annually **What you should know** Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. For more information on out-of-pocket costs for a plan, refer to the Evidence of Coverage.

Medical and Hospital Benefits	**WellCare Premier (PPO)** **H7175001000** **NC**
[PA] Services may require prior authorization	

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
Caswell, Durham, Orange, Person, Warren	**Avery, Buncombe, Haywood, Henderson, Jackson, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, Yancey**
$0.00 **What you should know** You must continue to pay your Medicare Part B premium.	**$0.00** **What you should know** You must continue to pay your Medicare Part B premium.
In-Network No Deductible **What you should know** See the Prescription Drug Benefits section of this document for Part D Prescription Drug Deductible information.	**In-Network** No Deductible **What you should know** See the Prescription Drug Benefits section of this document for Part D Prescription Drug Deductible information.
In-Network **$6,700** annually **Combined and/or Out-of-Network** Not Applicable **What you should know** Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. For more information on out-of-pocket costs for a plan, refer to the Evidence of Coverage.	**In-Network** **$6,700** annually **Combined and/or Out-of-Network** Not Applicable **What you should know** Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. For more information on out-of-pocket costs for a plan, refer to the Evidence of Coverage.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC

Medical and Hospital Benefits	WellCare Premier (PPO) H7175001000 NC
[R] Services may require a referral from your doctor Note: PPO plans do not require a prior authorization or referral for out-of-network services.	
Inpatient Hospital Coverage[PA,R]	**In-Network** **$325 co-pay per day for days 1-5 and a $0 co-pay per day for days 6-90** **Out-of-Network** **35% of the total cost for days 1-90** **What you should know** Our plan covers a specified number of days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information.
Outpatient Hospital Coverage[PA,R]	**In-Network** **$100** co-pay per non-surgery service / **$250** co-pay per surgery service **Out-of-Network** **35%** coinsurance for surgical and non-surgical services **What you should know** Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient setting.
Outpatient Hospital Observation Services[PA,R]	**In-Network** **$90** co-pay (ER) / **$250** co-pay (Outpatient) **Out-of-Network** **35%** coinsurance per stay **What you should know** Your cost for Outpatient Hospital Observation Services when you enter through ER and/or enter observation status through an outpatient setting.
Ambulatory Surgery Center (ASC)[PA,R]	**In-Network**

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$350 co-pay per day for days 1-5 and a $0 co-pay per day for days 6-90** **Out-of-Network** Not Covered **What you should know** Our plan covers a specified number of days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information.	**In-Network** **$350 co-pay per day for days 1-5 and a $0 co-pay per day for days 6-90** **Out-of-Network** Not Covered **What you should know** Our plan covers a specified number of days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information.
In-Network **$250** co-pay per non-surgery service / **$400** co-pay per surgery service **Out-of-Network** Not Covered **What you should know** Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient setting.	**In-Network** **$250** co-pay per non-surgery service / **$400** co-pay per surgery service **Out-of-Network** Not Covered **What you should know** Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient setting.
In-Network **$90** co-pay (ER) / **$400** co-pay (Outpatient) **Out-of-Network** Not Covered **What you should know** Your cost for Outpatient Hospital Observation Services when you enter through ER and/or enter observation status through an outpatient setting.	**In-Network** **$90** co-pay (ER) / **$400** co-pay (Outpatient) **Out-of-Network** Not Covered **What you should know** Your cost for Outpatient Hospital Observation Services when you enter through ER and/or enter observation status through an outpatient setting.
In-Network	**In-Network**

Medical and Hospital Benefits	WellCare Premier (PPO) H7175001000 NC
	$200 co-pay **Out-of-Network** **35%** coinsurance
Doctor Visits Primary Care Provider (PCP)	**In-Network** **$0** co-pay **Out-of-Network** **$25** co-pay **What you should know** Your PCP is the doctor who will handle most of your health care services.
Specialist[PA,R]	**In-Network** **$30** co-pay **Out-of-Network** **$50** co-pay
Other Healthcare Professionals[PA,R] (e.g. Physician Assistant or Nurse Practitioner)	**In-Network** **$0** co-pay (PCP office) **$30** co-pay (specialist office) **$30** co-pay (clinical/pharmacy setting) **Out-of-Network** **$25** co-pay (PCP office) **$50** co-pay (specialist office) **$30** co-pay (clinical/pharmacy setting)
Preventive Care Abdominal aortic aneurysm screening; Alcohol misuse counseling; Bone mass measurement; Breast cancer screening (mammogram); Cardiovascular disease	**In-Network** **$0** co-pay

WellCare Value (HMO) **H0712022000** **NC**	**WellCare Value (HMO)** **H0712023000** **NC**
$225 co-pay **Out-of-Network** Not Covered	**$225** co-pay **Out-of-Network** Not Covered
In-Network **$0** co-pay **Out-of-Network** Not Covered **What you should know** Your PCP is the doctor who will handle most of your health care services.	**In-Network** **$0** co-pay **Out-of-Network** Not Covered **What you should know** Your PCP is the doctor who will handle most of your health care services.
In-Network **$45** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered
In-Network **$0** co-pay (PCP office) **$45** co-pay (specialist office) **$45** co-pay (clinical/pharmacy setting) **Out-of-Network** Not Covered	**In-Network** **$0** co-pay (PCP office) **$40** co-pay (specialist office) **$45** co-pay (clinical/pharmacy setting) **Out-of-Network** Not Covered
In-Network **$0** co-pay	**In-Network** **$0** co-pay

Medical and Hospital Benefits	WellCare Premier (PPO) H7175001000 NC
(behavioral therapy); Cardiovascular screenings; Cervical and vaginal cancer screening; Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy); Depression screening; Diabetes screenings; HIV screening; Medical nutrition therapy services; Obesity screening and counseling; Prostate cancer screenings (PSA); Sexually transmitted infections screening and counseling; Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease); Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots; "Welcome to Medicare" preventive visit (one-time); Annual Wellness visit; Hepatitis B Virus Screening; Lung Cancer Screening and Medicare Diabetes Prevention Program (MDPP).	**Out-of-Network** **$0** co-pay **What you should know** Other preventive services are available. There are some covered services that have a cost. Stay healthy by getting your Annual Wellness Visit. During the visit, you can work with your PCP to schedule all preventive screenings and care. Any additional preventive services approved by Medicare during the contract year will be covered.

Emergency Care / Urgently Needed Services	WellCare Premier (PPO) H7175001000 NC
Emergency Care	**$90** co-pay **What you should know** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Worldwide Emergency Coverage	**$90** co-pay

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
Out-of-Network Not Covered **What you should know** Other preventive services are available. There are some covered services that have a cost. Stay healthy by getting your Annual Wellness Visit. During the visit, you can work with your PCP to schedule all preventive screenings and care. Any additional preventive services approved by Medicare during the contract year will be covered.	**Out-of-Network** Not Covered **What you should know** Other preventive services are available. There are some covered services that have a cost. Stay healthy by getting your Annual Wellness Visit. During the visit, you can work with your PCP to schedule all preventive screenings and care. Any additional preventive services approved by Medicare during the contract year will be covered.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
$90 co-pay **What you should know** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	**$90** co-pay **What you should know** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
$90 co-pay	**$90** co-pay

Emergency Care / Urgently Needed Services	WellCare Premier (PPO) H7175001000 NC
	What you should know Worldwide Emergency and worldwide urgently needed services are subject to a **$25,000** maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission.
Urgently Needed Services	**$30** co-pay **What you should know** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
Worldwide Urgent Coverage	**$90** co-pay **What you should know** Worldwide Emergency and worldwide urgently needed services are subject to a **$25,000** maximum plan coverage.

Diagnostic Services / Labs / Imaging	WellCare Premier (PPO) H7175001000 NC
Lab Services[PA,R] (Medicare approved lab work)	**In-Network** **$0** co-pay **Out-of-Network** **35%** coinsurance
Diagnostic Radiology Services[PA,R] (MRI/CT/PET scans in specialist office or free standing facility / outpatient setting)	**In-Network** **$100** co-pay / **$200** co-pay **Out-of-Network** **35%** coinsurance **What you should know** You pay $0 for mammograms and DEXA scans.
Diagnostic Tests and Procedures[PA,R] (Basic / Advanced)	**In-Network** **$0** co-pay / **$50** co-pay **Out-of-Network** **35%** coinsurance
Therapeutic Radiology Services[PA,R] (radiation treatment for cancer in a specialist office or free standing facility / outpatient setting)	**In-Network**

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
What you should know Worldwide Emergency and worldwide urgently needed services are subject to a **$25,000** maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission.	**What you should know** Worldwide Emergency and worldwide urgently needed services are subject to a **$25,000** maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission.
$45 co-pay **What you should know** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	**$45** co-pay **What you should know** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
$90 co-pay **What you should know** Worldwide Emergency and worldwide urgently needed services are subject to a **$25,000** maximum plan coverage.	**$90** co-pay **What you should know** Worldwide Emergency and worldwide urgently needed services are subject to a **$25,000** maximum plan coverage.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$0** co-pay **Out-of-Network** Not Covered	**In-Network** **$0** co-pay **Out-of-Network** Not Covered
In-Network **20%** coinsurance **Out-of-Network** Not Covered **What you should know** You pay $0 for mammograms and DEXA scans.	**In-Network** **20%** coinsurance **Out-of-Network** Not Covered **What you should know** You pay $0 for mammograms and DEXA scans.
In-Network **$50** co-pay / **$100** co-pay **Out-of-Network** Not Covered	**In-Network** **$45** co-pay / **$100** co-pay **Out-of-Network** Not Covered
In-Network	**In-Network** **$40** co-pay /

Diagnostic Services / Labs / Imaging	WellCare Premier (PPO) H7175001000 NC
	$30 co-pay / **20%** coinsurance **Out-of-Network** **35%** coinsurance
Outpatient X-Ray[PA,R]	**In-Network** **$15** co-pay **Out-of-Network** **35%** coinsurance

Hearing Services	WellCare Premier (PPO) H7175001000 NC
Hearing Exam[PA,R] (Medicare Covered)	**In-Network** **$30** co-pay **Out-of-Network** **$50** co-pay
Routine Hearing Exam[PA,R]	**In-Network** **$0** co-pay **1** exam **every year** **Out-of-Network** **50%** coinsurance **1** exam **every year**
Hearing Aid Fitting/Evaluations[PA,R]	**In-Network** **$0** co-pay 1 every year **Out-of-Network** **50%** coinsurance 1 every year
Annual Hearing Aid Allowance[PA,R]	**In-Network** **$0** co-pay 1 hearing aid per year **$500** value **Out-of-Network** **50%** coinsurance 1 hearing aid per year **$500** value

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
$45 co-pay / **20%** coinsurance **Out-of-Network** Not Covered	**20%** coinsurance **Out-of-Network** Not Covered
In-Network **$45** co-pay **Out-of-Network** Not Covered	**In-Network** **$45** co-pay **Out-of-Network** Not Covered

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$45** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered
In-Network **$0** co-pay **1** exam **every year** **Out-of-Network** Not Covered	**In-Network** **$0** co-pay **1** exam **every year** **Out-of-Network** Not Covered
In-Network **$0** co-pay 1 every year **Out-of-Network** Not Covered	**In-Network** **$0** co-pay 1 every year **Out-of-Network** Not Covered
In-Network **$0** co-pay 2 hearing aids per year **$1,500** value **Out-of-Network** Not Covered	**In-Network** **$0** co-pay 2 hearing aids per year **$1,500** value **Out-of-Network** Not Covered

Hearing Services	WellCare Premier (PPO) H7175001000 NC
	What you should know Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.

Dental Services	WellCare Premier (PPO) H7175001000 NC
Preventive Services[PA,R]	**In-Network** **$0** co-pay for: Cleanings (1 every 6 months) Dental x-rays (1 Every 12 to 36 months) Oral exams (1 every 6 months) **Out-of-Network** **20%** coinsurance for Cleanings (1 every 6 months) Dental x-rays (1 Every 12 to 36 months) Oral exams (1 every 6 months)
Fluoride[PA,R]	**In-Network** **$0** co-pay (1 every year) **Out-of-Network** **20%** coinsurance (1 every year)
Comprehensive Services[PA,R]	
(Medicare Covered)	**In-Network** **$30** co-pay **Out-of-Network** **$50** co-pay
Restorative	1 every three years
Endodontics/Periodontics/Extractions	1 Endodontic procedure per tooth 1 Periodontic procedure every 6 to 36 months 1 Extraction per tooth

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
What you should know Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$0** co-pay for: Cleanings (1 every 6 months) Dental x-rays (1 Every 12 to 36 months) Oral exams (1 every 6 months) **Out-of-Network** Not Covered	**In-Network** **$0** co-pay for: Cleanings (1 every 6 months) Dental x-rays (1 Every 12 to 36 months) Oral exams (1 every 6 months) **Out-of-Network** Not Covered
In-Network **$0** co-pay (1 every year) **Out-of-Network** Not Covered	**In-Network** **$0** co-pay (1 every year) **Out-of-Network** Not Covered
In-Network **$45** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered
1 every three years	1 every three years
1 Endodontic procedure per tooth 1 Periodontic procedure every 6 to 36 months 1 Extraction per tooth	1 Endodontic procedure per tooth 1 Periodontic procedure every 6 to 36 months 1 Extraction per tooth

Dental Services	WellCare Premier (PPO) H7175001000 NC
Prosthodontics, Other Oral/Maxillofacial Surgery	1 Prosthodontic procedure every 12 to 60 months 1 Oral Maxillofacial procedure every 60 months or per lifetime Other services every 6 to 24 months **What you should know** This plan includes coverage of preventive and comprehensive services up to **$1,000**, including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge or a crown and a root canal.

Vision Services	WellCare Premier (PPO) H7175001000 NC
Eye Exams[PA,R] (Medicare Covered)	**In-Network** **$0** co-pay (Medicare-covered diabetes retinopathy screening) **$30** co-pay (all other Medicare-covered eye exams) **Out-of-Network** **$0** co-pay (Medicare-covered diabetes retinopathy screening) **$50** co-pay (all other Medicare-covered eye exams)
Routine Eye Exams (Refraction)[PA,R]	**In-Network** **$0** co-pay 1 exam per year **Out-of-Network** **30%** coinsurance 1 exam per year
Glaucoma Screening[R]	**In-Network** **$0** co-pay **Out-of-Network** **$0** co-pay
Eyewear[PA,R] (Medicare Covered)	**In-Network** **$0** co-pay **Out-of-Network** **$50** co-pay

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
1 Prosthodontic procedure every 12 to 60 months 1 Oral Maxillofacial procedure every 60 months or per lifetime **What you should know** This plan includes coverage of preventive and comprehensive services up to **$750**, including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge and a root canal.	1 Prosthodontic procedure every 12 to 60 months 1 Oral Maxillofacial procedure every 60 months or per lifetime **What you should know** This plan includes coverage of preventive and comprehensive services up to **$750**, including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge and a root canal.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$0** co-pay (Medicare-covered diabetes retinopathy screening) **$45** co-pay (all other Medicare-covered eye exams) **Out-of-Network** Not Covered	**In-Network** **$0** co-pay (Medicare-covered diabetes retinopathy screening) **$40** co-pay (all other Medicare-covered eye exams) **Out-of-Network** Not Covered
In-Network **$0** co-pay 1 exam per year **Out-of-Network** Not Covered	**In-Network** **$0** co-pay 1 exam per year **Out-of-Network** Not Covered
In-Network **$0** co-pay **Out-of-Network** Not Covered	**In-Network** **$0** co-pay **Out-of-Network** Not Covered
In-Network **$0** co-pay **Out-of-Network** Not Covered	**In-Network** **$0** co-pay **Out-of-Network** Not Covered

Vision Services	WellCare Premier (PPO) H7175001000 NC
Contact Lenses, Eye Glasses, Eye Glass Lenses, Eye Glass Frames[PA,R]	**In-Network** **$0** co-pay 1 pair of contacts or glasses (lenses and/or frames) per year Up to **$100** **Out-of-Network** **30%** coinsurance 1 pair of contacts or glasses (lenses and/or frames) per year Up to **$100**

Mental Health Services	WellCare Premier (PPO) H7175001000 NC
Inpatient Mental Health Services[PA,R]	**In-Network** **$350** co-pay per day for days 1-5 and a **$0** co-pay per day for days 6-90 **Out-of-Network** **35%** of the total cost for days 1-90 **What you should know** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital
Outpatient Mental Health Services[PA,R]	
Per session for individual therapy	**In-Network** **$40** co-pay **Out-of-Network** **35%** coinsurance
Per session for group therapy	**In-Network** **$40** co-pay **Out-of-Network** **35%** coinsurance
Partial Hospitalization[PA,R]	**In-Network** **$55** co-pay **Out-of-Network**

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$0** co-pay 1 pair of contacts or glasses (lenses and/or frames) per year Up to **$200** **Out-of-Network** Not Covered	**In-Network** **$0** co-pay 1 pair of contacts or glasses (lenses and/or frames) per year Up to **$200** **Out-of-Network** Not Covered

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$400** co-pay per day for days 1-4 and a **$0** co-pay per day for days 5-90 **Out-of-Network** Not Covered **What you should know** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital	**In-Network** **$400** co-pay per day for days 1-4 and a **$0** co-pay per day for days 5-90 **Out-of-Network** Not Covered **What you should know** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital
In-Network **$40** co-pay **Out-of-Network** Not Covered **In-Network** **$40** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered **In-Network** **$40** co-pay **Out-of-Network** Not Covered
In-Network **$55** co-pay **Out-of-Network**	**In-Network** **$55** co-pay **Out-of-Network**

Mental Health Services	WellCare Premier (PPO) H7175001000 NC
	35% coinsurance

Skilled Nursing Facility (SNF)	WellCare Premier (PPO) H7175001000 NC
Skilled Nursing Facility (SNF)[PA,R]	**In-Network** **$0 co-pay per day for days 1-20 and a $178.00 co-pay per day for days 21-100** **Out-of-Network** **$0** co-pay per day for days 1-20 and a **$178.00** co-pay per day for days 21-100 **What you should know** Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a SNF and ends when you haven't received any SNF care for 60 consecutive days. There is no limit to the number of benefit periods you may have.

Therapy and Rehabilitation Services	WellCare Premier (PPO) H7175001000 NC
Physical Therapy and Speech-Language Therapy[PA,R]	**In-Network** **$40** co-pay **Out-of-Network** **35%** coinsurance
Occupational Therapy[PA,R]	**In-Network** **$40** co-pay **Out-of-Network** **35%** coinsurance
Cardiac Rehabilitation[PA,R]	**In-Network** **$45** co-pay **Out-of-Network** **35%** coinsurance
Pulmonary Rehabilitation[PA,R]	**In-Network** **$30** co-pay **Out-of-Network**

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
Not Covered	Not Covered

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$0 co-pay per day for days 1-20 and a $178.00 co-pay per day for days 21-100** **Out-of-Network** Not Covered **What you should know** Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a SNF and ends when you haven't received any SNF care for 60 consecutive days. There is no limit to the number of benefit periods you may have.	**In-Network** **$0 co-pay per day for days 1-20 and a $167.50 co-pay per day for days 21-100** **Out-of-Network** Not Covered **What you should know** Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a SNF and ends when you haven't received any SNF care for 60 consecutive days. There is no limit to the number of benefit periods you may have.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$40** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered
In-Network **$40** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered
In-Network **$45** co-pay **Out-of-Network** Not Covered	**In-Network** **$45** co-pay **Out-of-Network** Not Covered
In-Network **$30** co-pay **Out-of-Network**	**In-Network** **$30** co-pay **Out-of-Network**

Therapy and Rehabilitation Services	WellCare Premier (PPO) H7175001000 NC
	35% coinsurance
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)[PA,R]	**In-Network** **$30** co-pay **Out-of-Network** **35%** coinsurance

Ambulance and Transportation	WellCare Premier (PPO) H7175001000 NC
Ambulance[PA]	**(ground / air)** **$250** co-pay **What you should know** The cost share is not waived if you are admitted for inpatient hospital care.
Transportation[PA,R]	**In-Network** Not Covered **Out-of-Network** Not Covered

Medicare Part B Drugs	WellCare Premier (PPO) H7175001000 NC
Medicare Part B Drugs [PA]	**In-Network** **20%** coinsurance **Out-of-Network** **35%** coinsurance **What you should know** Includes chemotherapy and other Part B drugs

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
Not Covered	Not Covered
In-Network **$30** co-pay **Out-of-Network** Not Covered	**In-Network** **$30** co-pay **Out-of-Network** Not Covered

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
(ground / air) **$300** co-pay **What you should know** The cost share is not waived if you are admitted for inpatient hospital care.	**(ground / air)** **$300** co-pay **What you should know** The cost share is not waived if you are admitted for inpatient hospital care.
In-Network **$0** co-pay for 10 one-way trips every year **Out-of-Network** Not Covered **What you should know** The first step to staying healthy is getting to your doctor. That's why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need, when you need it. Call Customer Service 72 hours in advance to reserve a ride for your appointment.	**In-Network** **$0** co-pay for 10 one-way trips every year **Out-of-Networ**k Not Covered **What you should know** The first step to staying healthy is getting to your doctor. That's why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need, when you need it. Call Customer Service 72 hours in advance to reserve a ride for your appointment.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **20%** coinsurance **Out-of-Network** Not Covered **What you should know** Includes chemotherapy and other Part B drugs	**In-Network** **20%** coinsurance **Out-of-Network** Not Covered **What you should know** Includes chemotherapy and other Part B drugs

Prescription Drug Coverage	**WellCare Premier (PPO)** **H7175001000** **NC**
Part D Deductible	**$100** **Tiers 3 to 5**
Initial Coverage Stage (after you pay your deductible if applicable)	After you pay your deductible, You pay these co-pays or coinsurance amounts until your total yearly drug cost reaches **$4,020**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan at network retail pharmacies and mail order pharmacies.
Standard Retail, Mail and Preferred Mail Cost-Share (In-Network)	
Tier 1: Preferred Generic Drugs	
Standard Retail and Mail - 30 day supply	**$0**.00
Standard Retail and Mail - 90 day supply	**$0**.00
Preferred Mail - 30 day supply	**$0**.00
Preferred Mail - 90 day supply	**$0**.00
Tier 2: Generic Drugs	
Standard Retail and Mail - 30 day supply	**$10**.00
Standard Retail and Mail - 90 day supply	**$30**.00
Preferred Mail - 30 day supply	**$10**.00
Preferred Mail - 90 day supply	**$0**.00
Tier 3: Preferred Brand Drugs	
Standard Retail and Mail - 30 day supply	**$47**.00
Standard Retail and Mail - 90 day supply	**$141**.00
Preferred Mail - 30 day supply	**$47**.00
Preferred Mail - 90 day supply	**$94**.00
Tier 4: Non-Preferred Drugs	
Standard Retail and Mail - 30 day supply	**50**%
Standard Retail and Mail - 90 day supply	**50**%
Preferred Mail - 30 day supply	**50**%
Preferred Mail - 90 day supply	**50**%
Tier 5: Specialty Tier Drugs	
Standard Retail and Mail - 30 day supply	**31**%
Preferred Mail - 30 day supply	**31%**

WellCare Value (HMO) **H0712022000** **NC**	**WellCare Value (HMO)** **H0712023000** **NC**
$150 **Tiers 3 to 5**	**$165** **Tiers 3 to 5**
After you pay your deductible, You pay these co-pays or coinsurance amounts until your total yearly drug cost reaches **$4,020**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan at network retail pharmacies and mail order pharmacies.	After you pay your deductible, You pay these co-pays or coinsurance amounts until your total yearly drug cost reaches **$4,020**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan at network retail pharmacies and mail order pharmacies.
$0.00	**$0**.00
$0.00	**$0**.00
$0.00	**$0**.00
$0.00	**$0**.00
$12.00	**$12**.00
$36.00	**$36**.00
$12.00	**$12**.00
$0.00	**$0**.00
$45.00	**$47**.00
$135.00	**$141**.00
$45.00	**$47**.00
$90.00	**$94**.00
45%	**45**%
45%	**45**%
45%	**45**%
45%	**45**%
30%	**30**%
30%	**30%**

Prescription Drug Coverage	WellCare Premier (PPO) H7175001000 NC
What you should know	Preferred Mail: 90-day supply of Tier 1 and Tier 2 prescription drugs for a $0 co-pay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day co-pays, if applicable. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and co-pays. Standard Retail and Mail: You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan's cost of the drug minus the co-pay or coinsurance for drugs purchased out-of-network until total yearly drug costs reach **$4,020**. You will likely have to pay the pharmacy's full charge for the drugs and submit documentation to receive reimbursement. Cost-sharing may change depending on the pharmacy you use and when you move from one phase of the Part D benefit to another, your cost-sharing may change as well. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,020**. After you enter the coverage gap, you pay **25**% of the plan's cost for covered brand name drugs and **25**% of the plan's cost for covered generic drugs until your out-of-pocket costs total **$6,350** which is the end of the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350,** you pay the greater of: • **5%** of the cost; or • **$3.60** co-pay for generics (including brand drugs treated

WellCare Value (HMO) **H0712022000** **NC**	**WellCare Value (HMO)** **H0712023000** **NC**
Preferred Mail: 90-day supply of Tier 1 and Tier 2 prescription drugs for a $0 co-pay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day co-pays, if applicable. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and co-pays. Standard Retail and Mail: You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan's cost of the drug minus the co-pay or coinsurance for drugs purchased out-of-network until total yearly drug costs reach **$4,020**. You will likely have to pay the pharmacy's full charge for the drugs and submit documentation to receive reimbursement. Cost-sharing may change depending on the pharmacy you use and when you move from one phase of the Part D benefit to another, your cost-sharing may change as well. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.	Preferred Mail: 90-day supply of Tier 1 and Tier 2 prescription drugs for a $0 co-pay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day co-pays, if applicable. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and co-pays. Standard Retail and Mail: You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan's cost of the drug minus the co-pay or coinsurance for drugs purchased out-of-network until total yearly drug costs reach **$4,020**. You will likely have to pay the pharmacy's full charge for the drugs and submit documentation to receive reimbursement. Cost-sharing may change depending on the pharmacy you use and when you move from one phase of the Part D benefit to another, your cost-sharing may change as well. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,020**. After you enter the coverage gap, you pay **25**% of the plan's cost for covered brand name drugs and **25**% of the plan's cost for covered generic drugs until your out-of-pocket costs total **$6,350** which is the end of the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,020**. After you enter the coverage gap, you pay **25**% of the plan's cost for covered brand name drugs and **25**% of the plan's cost for covered generic drugs until your out-of-pocket costs total **$6,350** which is the end of the coverage gap.
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350,** you pay the greater of: • **5%** of the cost; or • **$3.60** co-pay for generics (including brand drugs treated	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350,** you pay the greater of: • **5%** of the cost; or • **$3.60** co-pay for generics (including brand drugs treated

Prescription Drug Coverage	WellCare Premier (PPO) H7175001000 NC
	as generic) or • **$8.95** co-pay for all other drugs.

Additional Support Benefits	WellCare Premier (PPO) H7175001000 NC
Chiropractic Care[PA,R]	
Medicare Covered	**In-Network** **$20** co-pay **Out-of-Network** **35%** coinsurance
Home Health Care[PA,R]	**In-Network** **$0** co-pay **Out-of-Network** **35%** coinsurance **What you should know** Covered services include part-time or intermittent Skilled Nursing and home health-aide services including physical therapy, occupational therapy, and speech therapy, medical and social services, medical equipment & supplies.
Outpatient Substance Abuse[PA,R]	
Individual Therapy	**In-Network** **$40** co-pay **Out-of-Network** **35%** coinsurance
Group Therapy	**In-Network** **$40** co-pay **Out-of-Network** **35%** coinsurance
Opioid Treatment Services[PA,R]	**In-Network** **$30** co-pay **Out-of-Network** **35%** coinsurance

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
as generic) or • **$8.95** co-pay for all other drugs.	as generic) or • **$8.95** co-pay for all other drugs.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$20** co-pay **Out-of-Network** Not Covered	**In-Network** **$20** co-pay **Out-of-Network** Not Covered
In-Network **$0** co-pay **Out-of-Network** Not Covered **What you should know** Covered services include part-time or intermittent Skilled Nursing and home health-aide services including physical therapy, occupational therapy, and speech therapy, medical and social services, medical equipment & supplies.	**In-Network** **$0** co-pay **Out-of-Network** Not Covered **What you should know** Covered services include part-time or intermittent Skilled Nursing and home health-aide services including physical therapy, occupational therapy, and speech therapy, medical and social services, medical equipment & supplies.
In-Network **$40** co-pay **Out-of-Network** Not Covered **In-Network** **$40** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered **In-Network** **$40** co-pay **Out-of-Network** Not Covered
In-Network **$45** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered

Additional Support Benefits	WellCare Premier (PPO) H7175001000 NC
	What you should know Opioid treatment services include FDA-approved opioid agonist and antagonist treatment medications, substance counseling and individual and/or group therapy.
Renal Dialysis[R]	**In-Network** **20%** coinsurance **Out-of-Network** **35%** coinsurance
Over-The-Counter (OTC) Health Items	**$75** every quarter **What you should know** Our plan will pay for the purchase of covered over-the counter items. Please visit our website to see our list of covered over-the counter items.
Meals	
Post-Acute Meals[PA,R]	**$0** co-pay **What you should know** The Plan offers home-delivered meals immediately following an inpatient hospital stay to aid in members' recovery. The total benefit duration is 14-days with a maximum of 10 meals.
Chronic Meals[PA,R]	**$0** co-pay **What you should know** You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modifications. Members receive up to 21 meals per week, for up to 2 weeks, for up to 2 conditions for a maximum of 84 meals per year.

Medical Equipment / Supplies / Services	WellCare Premier (PPO) H7175001000 NC
Durable Medical Equipment (DME)[PA] **(e.g., wheelchairs, oxygen)**	**In-Network** **20%** coinsurance **Out-of-Network** **35%** coinsurance
Prosthetics (e.g., braces, artificial limbs)[PA]	**In-Network**

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
What you should know Opioid treatment services include FDA-approved opioid agonist and antagonist treatment medications, substance counseling and individual and/or group therapy.	**What you should know** Opioid treatment services include FDA-approved opioid agonist and antagonist treatment medications, substance counseling and individual and/or group therapy.
In-Network **20%** coinsurance **Out-of-Network** Not Covered	**In-Network** **20%** coinsurance **Out-of-Network** Not Covered
$23 every month **What you should know** Our plan will pay for the purchase of covered over-the counter items. Please visit our website to see our list of covered over-the counter items.	**$23** every month **What you should know** Our plan will pay for the purchase of covered over-the counter items. Please visit our website to see our list of covered over-the counter items.
$0 co-pay **What you should know** The Plan offers home-delivered meals immediately following an inpatient hospital stay to aid in members' recovery. The total benefit duration is 14-days with a maximum of 10 meals. **$0** co-pay **What you should know** You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modifications. Members receive up to 21 meals per week, for up to 2 weeks, for up to 2 conditions for a maximum of 84 meals per year.	**$0** co-pay **What you should know** The Plan offers home-delivered meals immediately following an inpatient hospital stay to aid in members' recovery. The total benefit duration is 14-days with a maximum of 10 meals. **$0** co-pay **What you should know** You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modification. Members receive up to 21 meals per week, for up to 2 weeks, for up to 2 conditions for a maximum of 84 meals per year.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **20%** coinsurance **Out-of-Network** Not Covered	**In-Network** **20%** coinsurance **Out-of-Network** Not Covered
In-Network	**In-Network**

Medical Equipment / Supplies / Services	WellCare Premier (PPO) H7175001000 NC
	20% coinsurance **Out-of-Network** **35%** coinsurance
Diabetic Monitoring Supplies[PA]	**In-Network** **$0** co-pay **Out-of-Network** **35%** coinsurance **What you should know** Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions.
Medical Supplies[PA]	**In-Network** **20%** coinsurance **Out-of-Network** **35%** coinsurance
Diabetic Therapeutic Shoes and Inserts[PA]	**In-Network** **20%** coinsurance **Out-of-Network** **35%** coinsurance
Diabetic Self-Management Training	**In-Network** **$0** co-pay **Out-of-Network** **$0** co-pay

Foot Care	WellCare Premier (PPO) H7175001000 NC
Podiatry Services[PA,R] (Medicare Covered)	**In-Network** **$30** co-pay **Out-of-Network** **$50** co-pay

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
20% coinsurance **Out-of-Network** Not Covered	**20%** coinsurance **Out-of-Network** Not Covered
In-Network **$0** co-pay **Out-of-Network** Not Covered **What you should know** Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions.	**In-Network** **$0** co-pay **Out-of-Network** Not Covered **What you should know** Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions.
In-Network **20%** coinsurance **Out-of-Network** Not Covered	**In-Network** **20%** coinsurance **Out-of-Network** Not Covered
In-Network **20%** coinsurance **Out-of-Network** Not Covered	**In-Network** **20%** coinsurance **Out-of-Network** Not Covered
In-Network **$0** co-pay **Out-of-Network** Not Covered	**In-Network** **$0** co-pay **Out-of-Network** Not Covered

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
In-Network **$45** co-pay **Out-of-Network** Not Covered	**In-Network** **$40** co-pay **Out-of-Network** Not Covered

Wellness Programs	WellCare Premier (PPO) H7175001000 NC
Fitness	**$0** co-pay **What you should know** This benefit covers an annual membership at a participating health club or fitness center. If a member does not wish to use a network facility, they can choose from available exercise programs to be shipped to them at no cost. A Fitbit fitness tracker is included in the home kit.
Additional Routine Annual Physical	**In-Network** **$0** co-pay **Out-of-Network** **$0** co-pay **What you should know** Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.
24-Hour Nurse Advice Line	**$0** co-pay

WellCare Health Plans, Inc., is an HMO, PPO, PFFS plan with a Medicare contract. Enrollment in the plans depend on contract renewal. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. Our plans use a formulary.

You have the choice to sign up for automated mail service delivery. You can get prescription drugs shipped to your home through our network mail service delivery program. You should expect to receive your prescription drugs within 10–14 calendar days from the time that the mail service pharmacy receives the order. If you do not receive your prescription drugs within this time, please contact us at 1-866-892-9006 (TTY 1-866-507-6135), 24 hours a day, seven days a week, or visit mailrx.wellcare.com.

Out-of-network/non-contracted providers are under no obligation to treat WellCare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Please contact your plan for details.

WellCare Value (HMO) H0712022000 NC	WellCare Value (HMO) H0712023000 NC
$0 co-pay **What you should know** This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit fitness tracker is included in the home kit.	**$0** co-pay **What you should know** This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit fitness tracker is included in the home kit.
In-Network **$0** co-pay **Out-of-Network** Not Covered **What you should know** Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.	**In-Network** **$0** co-pay **Out-of-Network** Not Covered **What you should know** Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.
$0 co-pay	**$0** co-pay

Multi-Language Insert
Multi-language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-374-4056** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-374-4056** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-374-4056** (TTY: **711**) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-374-4056** (TTY: **711**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-374-4056** (TTY: **711**)번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-374-4056** (TTY: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-374-4056** (TTY: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-374-4056 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-374-4056** (TTY: **711**).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-374-4056** (TTY: **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-374-4056** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-374-4056** (TTY: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-374-4056** (TTY: **711**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-374-4056** (TTY: **711**) まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-374-4056** (TTY: **711**).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-374-4056 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-374-4056** (TTY: **711**) पर कॉल करें।

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-877-374-4056** (TTY (հեռատիպ)՝ **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-374-4056** (TTY: **711**).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-374-4056** (TTY: **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-877-374-4056** (TTY: **711**).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ**1-877-374-4056** (TTY: **711**)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-877-374-4056** (TTY: **711**) ਤੇ ਕਾਲ ਕਰੋ।.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-877-374-4056** (TTY: **711**)।

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-877-374-4056 (TTY: 711).

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-877-374-4056** (TTY: **711**).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-374-4056 (መስማት ለተሳናቸው: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-374-4056** (TTY: **711**).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-374-4056** (TTY: **711**).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-877-374-4056** (TTY: **711**).

ATENSIÓN: Yanggen un tungó [I linguahén Chamoru], i setbision linguahé gaige para hagu dibatde ha. Agang I **1-877-374-4056** (TTY: **711**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-374-4056** (TTY: **711**).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti **1-877-374-4056** (TTY: **711**).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-877-374-4056** (TTY: **711**).

DÍÍ BAA AKÓ NÍNÍZIN: Díí Diné bizaad bee yáníłti’go, saad bee áká’ánida’áwo’dę́ę́’, t’áá jiik’eh, ná hóló̜. Kojį’ hódíílnih **1-877-374-4056** (TTY: **711**).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-877-374-4056** (TTY: **711**).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-374-4056** (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: **711**).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-877-374-4056** (телетайп: **711**).

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܬܟܚܝܢ ܠܘܟ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-877-374-4056 (TTY: 711).

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call **1-877-374-4056** (TTY: **711**).

ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-877-374-4056** (टिटिवाइ: **711**) ।

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel **1-877-374-4056** (TTY: **711**).

ပာ်သူၣ်ပာ်သး–နမ့ၢ်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူၣ်လၢာ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-877-374-4056 (TTY: 711).

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk **1-877-374-4056** (TTY: **711**).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-877-374-4056 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-877-374-4056** (TTY: **711**).

MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-877-374-4056** (TTY: **711**).

E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā **1-877-374-4056** (TTY: **711**).

FAKATOKANGA’I: Kapau ‘oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta’etotongi, pea teke lava ‘o ma’u ia. Telefoni mai **1-877-374-4056** (TTY: **711**).

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Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call **1-877-374-4056** (TTY: **711**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-374-4056** (TTY: **711**).

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-877-374-4056** (TTY: **711**).

ANOMPA PA PISAH: [Chahta] makilla ish anompoli hokma, kvna hosh Nahollo Anompa ya pipilla hosh chi tosholahinla. Atoko, hattak yvmma im anompoli chi bvnnakmvt, holhtina pa payah: **1-877-374-4056** (TTY: **711**).

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu **1-877-374-4056** (TTY: **711**).

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call **1-877-374-4056** (TTY: **711**).

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi **1-877-374-4056** (TTY: **711**).

DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. **1-877-374-4056** (TTY: **711**) irtibat numaralarını arayın.

ئاگادارى: ئەگەر بە زمانى كوردى قسە دەكەيت، خزمەتگوزارىەكانى يارمەتى زمان، بەخۆڕاىى، بۆ تۆ بەردەستە. پەيوەندى بە 1-877-374-4056 (TTY (711 بكە.

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-374-4056** (TTY: **711**).

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. **1-877-374-4056** (TTY: **711**) కు కాల్ చేయండి.

PIŋ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atö kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë **1-877-374-4056** (TTY: **711**).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring **1-877-374-4056** (TTY: **711**).

ATENCIÓ: Si parleu Català, teniu disponible un servei d”ajuda lingüística sense cap càrrec. Truqueu al **1-877-374-4056** (TTY o teletip: **711**).

Discrimination is Against the Law

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare Health Plans, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact WellCare Customer Service for help or you can ask Customer Service to put you in touch with a Civil Rights Coordinator who works for WellCare.

If you believe that WellCare Health Plans, Inc., has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

WellCare Health Plans, Inc.
Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384
Telephone: **1-866-530-9491** TTY: **711** Fax: **1-866-388-1769** Email: **OperationalGrievance@wellcare.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a WellCare Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

* This Nondiscrimination Notice also applies to all subsidiaries of WellCare Health Plans, Inc.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-866-527-0056** (TTY **711**).

Understanding the Benefits

☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **www.wellcare.com/medicare** or call 1-866-527-0056 to view a copy of the EOC.

☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.

☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Contact Us

For more information, please call us at the phone number below or visit us at www.wellcare.com/medicare.

- Not yet a member? Please call us toll-free at **1-866-527-0056** (TTY **711**). Your call may be answered by a licensed agent.
- Already a member? Please call us toll-free at **1-833-444-9088** (TTY **711**).

Hours of Operation

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

Formularies and Directories

You can see our plan's Provider/Pharmacy Directory and our complete plan formulary (list of Part D prescription drugs) at our website: **www.wellcare.com/medicare**. Or, call us and we'll send you a copy. We're with our members every step of the way.

WellCare®
Beyond Healthcare. A Better You.

MedicareRx
Prescription Drug Coverage