

The WellCare Signature and Classic Prescription Drug Plan (PDP) formularies are divided into four tiers.

Signature (PDP) tiers are as follows: Tier 1 (generic), Tier 2 (preferred brand), Tier 3 (non-preferred brand), and Tier 4 (specialty) drugs.

Classic (PDP) tiers are as follows: Tier 1 (preferred generic), Tier 2 (generic and preferred brand), Tier 3 (generic and non-preferred brand), and Tier 4 (specialty) drugs.

WellCare offers both preferred and non-preferred mail-order. With WellCare's prescription mail-order process (preferred), you can order a 3-month supply of any Tier 1, 2 and 3 medication at approximately 2½ times your retail 1-month supply cost. Non-preferred 3-month mail-order costs are 3 times your retail 1-month supply cost. The below costs represent non-preferred mail order costs.

Note: The benefit information provided herein is a summary, not a comprehensive description of benefits. For more information contact the plan. Benefits, premium and/or co-payments/co-insurance may change on January 1, 2012.

	WellCare Choice (HMO-POS)	WellCare Premium (HMO-POS)
Total Estimated Annual Cost	\$1,474.04	\$2,218.32
	<input type="button" value="Enroll"/>	<input type="button" value="Enroll"/>
Medical Coverage ?		
Maximum Annual Out Of Pocket	\$3250.00	\$1750.00
Doctor Office Visits	See "Physical Exams," for more information. / HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. / \$10 copay for each primary care doctor visit for Medicare-covered benefits.	See "Physical Exams," for more information. / HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. / \$0 copay for each primary care doctor visit for Medicare-covered benefits.
Doctor Specialty Visits	\$30 copay for each specialist visit for Medicare-covered benefits.	\$15 copay for each specialist visit for Medicare-covered benefits.
Inpatient Hospital Care	No limit to the number of days covered by the plan each benefit period. / For Medicare-covered hospital stays: / Days 1 - 7: \$200 copay per day / Days 8 - 90: \$0 copay per day / \$0 copay for additional hospital days	No limit to the number of days covered by the plan each benefit period. / For Medicare-covered hospital stays: / Days 1 - 7: \$50 copay per day / Days 8 - 90: \$0 copay per day / \$0 copay for additional hospital days
	Authorization rules may apply. /	Authorization rules may apply. /

Skilled Nursing Facility (SNF)	Authorization rules may apply. / Plan covers up to 100 days each benefit period / No prior hospital stay is required. / For SNF stays: / Days 1 - 7: \$0 copay per day / Days 8 - 100: \$85 copay per day	Authorization rules may apply. / Plan covers up to 100 days each benefit period / No prior hospital stay is required. / For SNF stays: / Days 1 - 7: \$0 copay per day / Days 8 - 100: \$85 copay per day
Home Health Care	Authorization rules may apply. / \$0 to \$25 copay for each Medicare-covered home health visit.	Authorization rules may apply. / \$0 to \$15 copay for each Medicare-covered home health visit.
Immunizations	\$0 copay for Flu and Pneumonia vaccines. / No referral needed for Flu and pneumonia vaccines. / \$0 copay for Hepatitis B vaccine.	\$0 copay for Flu and Pneumonia vaccines. / No referral needed for Flu and pneumonia vaccines. / \$0 copay for Hepatitis B vaccine.
Outpatient Mental Health Care	Authorization rules may apply. / \$30 copay for each Medicare-covered individual therapy visit. / \$20 copay for each Medicare-covered group therapy visit.	Authorization rules may apply. / \$15 copay for each Medicare-covered individual therapy visit. / \$5 copay for each Medicare-covered group therapy visit.
Pharmacy Coverage ?		
Deductible	\$0.00	\$0.00
Initial Coverage Limit	\$2840.00	\$2840.00
One Month Supply (Retail) ?		
Generics	\$3.00	\$5.00
Preferred Brands	\$39.00	\$29.00
Non-Preferred Brands	\$79.00	\$59.00
Specialty Tiers	33%	33%
Three Month Supply (Mail Order) ?		
Generics	\$9.00	\$15.00
Preferred Brands	\$117.00	\$87.00
Non-Preferred Brands	\$237.00	\$177.00