



Summary of Benefits

***** Coordinated Care | Dual-Eligible Special Needs Plans *****



Connecticut

Fairfield, Hartford, New Haven, and Tolland Counties

WellCare of Connecticut, Inc. | H0712

01/01/12 - 12/31/12

WellCare Access (HMO SNP) | Plan 005



Section I - Introduction to Summary of Benefits

Thank you for your interest in WellCare Access (HMO SNP). Our plan is offered by WellCare of Connecticut, Inc./WellCare, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call WellCare Access (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call WellCare Access (HMO SNP) and ask for the "Evidence of Coverage."

You have choices in your health care.

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like WellCare Access (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call WellCare Access (HMO SNP) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How can I compare my options?

You can compare WellCare Access (HMO SNP) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where is WellCare Access (HMO SNP) available?

The service area for this plan includes: Fairfield, Hartford, New Haven, and Tolland counties, CT. You must live in one of these areas to join the plan.

Who is eligible to join WellCare Access (HMO SNP)?

You can join WellCare Access (HMO SNP) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area.

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However, individuals with End-Stage Renal Disease generally are not eligible to enroll in WellCare Access (HMO SNP) unless they are members of our organization and have been since their dialysis began.

You must also be enrolled in the Connecticut Department of Social Services to join this plan.

Please call the plan to see if you are eligible to join.

Can I choose my doctors?

WellCare Access (HMO SNP) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory by contacting our customer service number listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

Where can I get my prescriptions if I join this plan?

WellCare Access (HMO SNP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.wellcare.com. Our customer service number is listed at the end of this introduction.

WellCare Access (HMO SNP) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

Does my plan cover Medicare Part B or Part D drugs?

WellCare Access (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What is a prescription drug formulary?

WellCare Access (HMO SNP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at www.wellcare.com.

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If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of WellCare Access (HMO SNP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

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As a member of WellCare Access (HMO SNP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact WellCare Access (HMO SNP) for more details.

What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact WellCare Access (HMO SNP) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs administered through DME.

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Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the Web, you may use the Web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

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Please call WellCare for more information about WellCare Access (HMO SNP).



Visit us at www.wellcare.com or, call us:

Customer Service Hours:



Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 9:00 p.m. Eastern



Current members should call toll-free and locally (866)-635-7047 for questions related to the Medicare Advantage Program or Medicare Part D Prescription Drug program. (TTY/TDD (877)-247-6272)



Prospective members should call toll-free and locally (877)-817-5794 for questions related to the Medicare Advantage Program or Medicare Part D Prescription Drug program. (TTY/TDD (877)-247-6272)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the Web.

This document may be available in other formats such as Braille, large print or other alternate formats. This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en un idioma diferente al inglés. Para información adicional, llame a Servicio al Cliente al número de teléfono indicado más arriba.

If you have any questions about this plan's benefits or costs, please contact WellCare for details.

Section II - Summary of Benefits

For Contract H0712, Plan 005

BENEFIT		WELLCARE ACCESS (HMO SNP)
ORIGINAL MEDICARE		
<p>Important Information</p> <p>1 Premium and Other Important Information</p>	<p>In 2012 the monthly Part B Premium is \$0 and the annual Part B deductible amount is \$0. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General</p> <ul style="list-style-type: none"> * Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services ** Please consult with your plan about cost sharing when receiving services from out-of-network providers. \$0 monthly plan premium* <p>In-Network</p> <ul style="list-style-type: none"> \$0 annual deductible.* \$6,700 out-of-pocket limit for Medicare-covered services. <p>However, in this plan you will have no cost sharing responsibility for Medicare-covered services, based on your level of Medicaid eligibility.</p>
<p>2 Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).</p>

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Inpatient Care

3 Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)

For each benefit period:
Days 1 - 60: \$0 deductible
Days 61 - 90: \$0 per day
Days 91 - 150: \$0 per lifetime
reserve day

Call 1-800-MEDICARE
(1-800-633-4227) for
information about lifetime
reserve days.

Lifetime reserve days can only
be used once.

A "benefit period" starts the
day you go into a hospital or
skilled nursing facility. It ends
when you go for 60 days in a
row without hospital or skilled
nursing care. If you go into the
hospital after one benefit
period has ended, a new
benefit period begins. There is
no limit to the number of
benefit periods you can have.

In-Network

Plan covers 90 days each benefit period.

You will not be charged additional cost sharing for professional
services

\$0 annual deductible*

\$0 co-pay*

Except in an emergency, your doctor must tell the plan that you
are going to be admitted to the hospital.

BENEFIT**ORIGINAL MEDICARE****WELLCARE ACCESS (HMO SNP)****Inpatient Care****4 Inpatient Mental Health Care**

For each benefit period:
 Days 1 - 60: \$0 deductible
 Days 61 - 90: \$0 per day
 Days 91 - 150: \$0 per lifetime reserve day

You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

In-Network
\$0 co-pay*

You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

\$0 annual deductible*

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

5 Skilled Nursing Facility (SNF)
(in a Medicare-certified skilled nursing facility)

In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are:

Days 1 - 20: \$0 per day
 Days 21 - 100: \$0 per day
 100 days for each benefit period.

General

Authorization rules may apply.

In-Network

Plan covers up to 100 days each benefit period

No prior hospital stay is required.

\$0 annual deductible*

\$0 co-pay for SNF services*

BENEFIT**ORIGINAL MEDICARE****WELLCARE ACCESS (HMO SNP)****Inpatient Care**

5 Skilled Nursing Facility (SNF)
(in a Medicare-certified skilled nursing facility)

A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

6 Home Health Care
(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)

\$0 co-pay.

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered home health visits*

7 Hospice

You must get care from a Medicare-certified hospice.

General

You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

BENEFIT**ORIGINAL MEDICARE****WELLCARE ACCESS (HMO SNP)****Outpatient Care****8 Doctor Office Visits**

0% coinsurance

In-Network

\$0 co-pay for each primary care doctor visit for Medicare-covered benefits.*

\$0 co-pay for the cost of each in-area, network urgent care Medicare-covered visit.*

\$0 co-pay for each specialist doctor visit for Medicare-covered benefits.*

9 Chiropractic Services

Supplemental routine care not covered

In-Network

\$0 co-pay for Medicare-covered chiropractic visits*

Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.

10 Podiatry Services

Supplemental routine care not covered.

In-Network

\$0 co-pay for Medicare-covered podiatry benefits.*

Medicare-covered podiatry benefits are for medically-necessary foot care.

BENEFIT**ORIGINAL MEDICARE****WELLCARE ACCESS (HMO SNP)****Outpatient Care****11** Outpatient Mental Health Care

0% coinsurance for most outpatient mental health services

0% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program.

"Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered Mental Health visits*

\$0 co-pay for each Medicare-covered visit with a psychiatrist*

\$0 co-pay for Medicare-covered partial hospitalization program services*

12 Outpatient Substance Abuse Care

0% coinsurance

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered visits*

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Outpatient Care

13 Outpatient Services/
Surgery

0% coinsurance for the doctor's services
0% coinsurance for ambulatory surgical center facility services

General

Authorization rules may apply.

In-Network

\$0 co-pay for each Medicare-covered ambulatory surgical center visit*

\$0 co-pay for each Medicare-covered outpatient hospital facility visit*

14 Ambulance Services
(medically necessary ambulance services)

0% coinsurance

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered ambulance benefits.*

15 Emergency Care

(You may go to any emergency room if you reasonably believe you need emergency care.)

0% coinsurance for the doctor's services
0% outpatient hospital facility emergency services.
Not covered outside the U.S. except under limited circumstances.

General

\$0 co-pay for Medicare-covered emergency room visits*

Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.

If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.

BENEFIT

ORIGINAL MEDICARE

WELL-CARE ACCESS (HMO SNP)

Outpatient Care

16 Urgently Needed Care
(This is NOT emergency care, and in most cases, is out of the service area.)

0% coinsurance

NOT covered outside the U.S. except under limited circumstances.

General

\$0 co-pay for Medicare-covered urgently-needed-care visits*
If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.

17 Outpatient Rehabilitation Services
(Occupational Therapy, Physical Therapy, Speech and Language Therapy)

0% coinsurance

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered Occupational Therapy visits*
\$0 co-pay for Medicare-covered Physical and/or Speech and Language Therapy visits*

Outpatient Medical Services and Supplies

18 Durable Medical Equipment
(includes wheelchairs, oxygen, etc.)

0% coinsurance

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered items*

19 Prosthetic Devices
(includes braces, artificial limbs and eyes, etc.)

0% coinsurance

General

Authorization rules may apply.

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Outpatient Medical Services and Supplies

<p>19 Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>		<p>In-Network \$0 co-pay for Medicare-covered items*</p>
<p>20 Diabetes Programs and Supplies</p>	<p>0% coinsurance for diabetes self-management training 0% coinsurance for diabetes supplies 0% coinsurance for diabetic therapeutic shoes or inserts</p>	<p>General Authorization rules may apply. In-Network \$0 co-pay for diabetes self-management training* \$0 co-pay for: • Diabetes monitoring supplies* • Therapeutic shoes or inserts*</p>
<p>21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>0% coinsurance for diagnostic tests and X-rays \$0 co-pay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a</p>	<p>General Authorization rules may apply. In-Network \$0 co-pay for Medicare-covered: • Lab services* • Diagnostic procedures and tests* • X-rays* • Diagnostic radiology services (not including X-rays)* • Therapeutic radiology services*</p>

BENEFIT**ORIGINAL MEDICARE****WELLCARE ACCESS (HMO SNP)****Outpatient Medical Services and Supplies****21** Diagnostic Tests, X-Rays, Lab Services, and Radiology Services

suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.

0% coinsurance for the digital rectal exam and other related services.

Covered once a year for all men with Medicare over age 50.

22 Cardiac and Pulmonary Rehabilitation Services

0% coinsurance for Cardiac Rehabilitation services.

0% coinsurance for Pulmonary Rehabilitation services.

0% coinsurance for Intensive Cardiac Rehabilitation services

This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.

General

Authorization rules may apply.

In-Network

\$0 co-pay for:

- Medicare-covered Cardiac Rehabilitation Services*
- Medicare-covered Intensive Cardiac Rehabilitation Services*
- Medicare-covered Pulmonary Rehabilitation Services*

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Preventive Services

23 Preventive Services and Wellness/Education Programs

- No coinsurance, co-payment or deductible for the following:
- Abdominal Aortic Aneurysm Screening
 - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
 - Cardiovascular Screening
 - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk.
 - Colorectal Cancer Screening
 - Diabetes Screening
 - Influenza Vaccine
 - Hepatitis B Vaccine for people with Medicare who are at risk

General

\$0 co-pay for all preventive services covered under Original Medicare at zero cost sharing:

- Abdominal Aortic Aneurysm screening
- Bone Mass Measurement
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)
- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine
- HIV Screening
- Breast Cancer Screening (Mammogram)
- Medical Nutrition Therapy Services
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine
- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
- Smoking Cessation (Counseling to stop smoking)
- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Preventive Services

23 Preventive Services and Wellness/Education Programs

- HIV Screening. \$0 co-pay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. 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.
- Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.

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.

In-Network

The plan covers the following supplemental education/wellness programs:

- Written health education materials, including newsletters
- Health Club Membership/Fitness Classes
- Nursing Hotline

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Preventive Services

23 Preventive Services and Wellness/Education Programs

- Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.
- Prostate Cancer Screening Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Preventive Services

23 Preventive Services and Wellness/Education Programs

- Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.
- Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Preventive Services

24 Kidney Disease and Conditions

0% coinsurance for renal dialysis
 0% coinsurance for kidney disease education services

In-Network
 \$0 co-pay for renal dialysis*
 \$0 co-pay for kidney disease education services*

25 Outpatient Prescription Drugs

Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.

Drugs covered under Medicare Part B

General

\$0 annual deductible for Part B-covered drugs.*
 \$0 co-pay for Part B covered chemotherapy drugs and other Part-B covered drugs.*

Drugs covered under Medicare Part D

General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.wellcare.com on the Web.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service) providers.

The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Preventive Services

25 **Outpatient Prescription Drugs**

Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from WellCare Access (HMO SNP) for certain drugs.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and WellCare Access (HMO SNP) approves the exception, you will pay the generic cost share for generic drugs and the brand cost share for brand drugs.

In-Network

You pay a \$0 annual deductible.

BENEFIT

ORIGINAL MEDICARE

WELLWARE ACCESS (HMO SNP)

Preventive Services

25 Outpatient Prescription Drugs

Initial Coverage

Depending on your income and institutional status, you pay the following:

You pay \$0 co-pay for Tier 1 drugs until you reach the initial coverage limit of \$2,930 in total drug spend. Then depending on your income and institutional status, you pay the following for Tier 1 drugs:

- A \$0 (generic and brand) co-pay; or
- A \$1.10 (generic) or \$3.30 (brand) co-pay or
- A \$2.60 (generic) or \$6.50 (brand) co-pay

For Tier 2, 3, or 4 drugs, you pay the following co-pays depending on your income and institutional status until you reach the out of pocket threshold of \$4,700.

- A \$0 co-pay (generic and brand); or
- A \$1.10 (generic) or \$3.30 (brand) co-pay or
- A \$2.60 (generic) or \$6.50 (brand) co-pay

All co-pays count towards your initial coverage limit and out of pocket threshold.

Catastrophic Coverage

You pay a \$0 co-pay.

Preventive Services

25 Outpatient Prescription Drugs

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from WellCare Access (HMO SNP).

Out-of-Network Initial Coverage

Depending on your income and institutional status, you pay the following:

You pay \$0 co-pay for Tier 1 drugs until you reach the initial coverage limit of \$2,930 in total drug spend. Then depending on your income and institutional status, you pay the following for Tier 1 drugs:

- A \$0 (generic and brand) co-pay; or
- A \$1.10 (generic) or \$3.30 (brand) co-pay or
- A \$2.60 (generic) or \$6.50 (brand) co-pay

For Tier 2, 3, or 4 drugs, you pay the following co-pays depending on your income and institutional status until you reach the out of pocket threshold of \$4,700.

- A \$0 co-pay (generic and brand); or
- A \$1.10 (generic) or \$3.30 (brand) co-pay or
- A \$2.60 (generic) or \$6.50 (brand) co-pay

BENEFIT**ORIGINAL MEDICARE****WELLCARE ACCESS (HMO SNP)****Preventive Services****25** Outpatient Prescription Drugs

All co-pays count towards your initial coverage limit and out of pocket threshold.

Out-of-Network Catastrophic Coverage

You will be reimbursed in full for drugs purchased out-of-network.

26 Dental Services

Preventive dental services (such as cleaning) not covered.

General

Authorization rules may apply.

In-Network

- \$0 co-pay for Medicare-covered dental benefits*
- \$0 co-pay for up to 1 oral exam(s) every six months
- \$0 co-pay for up to 1 cleaning(s) every six months
- \$0 co-pay for up to 1 dental X-ray(s)

27 Hearing Services

Supplemental routine hearing exams and hearing aids not covered.

In-Network

- 0% of the cost for up to 1 supplemental routine hearing exam(s) every year
- 0% of the cost for up to 1 hearing aid fitting-evaluation(s) every three years
- \$0 co-pay for up to 1 hearing aid(s) every three years

\$50 plan coverage limit for supplemental routine hearing exams every year.

\$350 plan coverage limit for hearing aids every three years.

BENEFIT

ORIGINAL MEDICARE

WELLWARE ACCESS (HMO SNP)

Preventive Services

28 Vision Services

0% coinsurance for diagnosis and treatment of diseases and conditions of the eye.
 Supplemental routine eye exams and glasses not covered.
 Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.
 Annual glaucoma screenings covered for people at risk.

In-Network

- 0% of the cost for up to 1 supplemental routine eye exam(s) every year
 - \$0 co-pay for up to 1 pair(s) of glasses every year
 - \$0 co-pay for up to 1 pair(s) of contacts every year
 - \$0 co-pay for up to 1 pair(s) of lenses every year
 - \$0 co-pay for up to 1 frame(s) every year
- \$100 plan coverage limit for eye wear every year.

Over-the-Counter Items

Not covered.

General

Please visit our plan website to see our list of covered Over-the-Counter items.
 OTC items may be purchased only for the enrollee.
 Please contact the plan for specific instructions for using this benefit.

**Transportation
(Routine)**

Not covered.

In-Network

\$0 co-pay for up to 20 one-way trip(s) to plan approved location every year

BENEFIT

ORIGINAL MEDICARE

WELLCARE ACCESS (HMO SNP)

Preventive Services

Acupuncture

Not covered.

In-Network

This plan does not cover Acupuncture.

Medicaid - Summary of Benefits

For Contract H0712, Plan 005

BENEFIT		WELLCARE ACCESS (HMO SNP)
<p>Important Information</p> <p>Premium and Other Important Information</p>	<p>There are no premiums for CT Medicaid.</p>	<p>General</p> <p>* Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services</p> <p>** Please consult with your plan about cost sharing when receiving services from out-of-network providers.</p> <p>\$0 monthly plan premium*</p> <p>In-Network</p> <p>\$0 annual deductible.*</p> <p>\$6,700 out-of-pocket limit for Medicare-covered services. However, in this plan you will have no cost sharing responsibility for Medicare-covered services, based on your level of Medicaid eligibility.</p>
<p>Doctor and Hospital Choice</p> <p>(For more information, see Emergency - and Urgently Needed Care.)</p>	<p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services. Members should follow Medicare guidelines related to hospital and doctor choice.</p>	<p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).</p>

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Important Information**

\$0 co-pay for Medicaid-covered services.

Inpatient Care**Inpatient Hospital Care**
(Includes Substance Abuse and Rehabilitation)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.

\$0 co-pay for Medicaid-covered services.

In-Network

Plan covers 90 days each benefit period.

You will not be charged additional cost sharing for professional services

\$0 annual deductible*

\$0 co-pay*

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Inpatient Mental Health Care

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.

\$0 co-pay for Medicaid-covered services.

In-Network

\$0 co-pay*

You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

\$0 annual deductible*

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Inpatient Care****Skilled Nursing Facility (SNF)**
(In a Medicare-certified skilled nursing facility)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
\$0 co-pay for Medicaid-covered services.

General

Authorization rules may apply.

In-Network

Plan covers up to 100 days each benefit period
No prior hospital stay is required.
\$0 annual deductible*
\$0 co-pay for SNF services*

Home Health Care

(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
\$0 co-pay for Medicaid-covered services.

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered home health visits*

Hospice

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
Exclusions: If the member is eligible for Medicare Part A, Medicare is expected to pay for the service. Medicaid will not pay for hospice services

General

You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)**

Inpatient Care	Hospice	for a client eligible for Medicare. \$0 co-pay for Medicaid-covered services.	
Outpatient Care	Doctor Office Visits	For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for each primary care doctor visit for Medicare-covered benefits.* \$0 co-pay for the cost of each in-area, network urgent care Medicare-covered visit.* \$0 co-pay for each specialist doctor visit for Medicare-covered benefits.*
Chiropractic Services	For dual-eligible members, Medicaid will pay for the coinsurance where Medicare pays as primary. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Medicare-covered chiropractic visits* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	
Podiatry Services	For dual-eligible members, Medicaid will pay for only the coinsurance where Medicare pays as the primary. Effective 10/1/2011 and forward, Medicaid will pay for this	In-Network \$0 co-pay for Medicare-covered podiatry benefits.* Medicare-covered podiatry benefits are for medically-necessary foot care.	

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)**

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO SNP)
<p>Outpatient Care</p> <p>Podiatry Services</p>	<p>service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	
<p>Outpatient Mental Health Care</p>	<p>For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered Mental Health visits* \$0 co-pay for each Medicare-covered visit with a psychiatrist* \$0 co-pay for Medicare-covered partial hospitalization program services*</p>
<p>Outpatient Substance Abuse Care</p>	<p>For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered visits*</p>

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Outpatient Care****Outpatient Services/Surgery**

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
 \$0 co-pay for Medicaid-covered services.

General

Authorization rules may apply.

In-Network

\$0 co-pay for each Medicare-covered ambulatory surgical center visit*
 \$0 co-pay for each Medicare-covered outpatient hospital facility visit*

Ambulance Services
(medically necessary ambulance services)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
 \$0 co-pay for Medicaid-covered services.

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered ambulance benefits.*

Emergency Care

(You may go to any emergency room if you reasonably believe you need emergency care.)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
 \$0 co-pay for Medicaid-covered services.

General

\$0 co-pay for Medicare-covered emergency room visits*
 Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.

If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Outpatient Care**

Urgently Needed Care
(This is NOT emergency care, and in most cases, is out of the service area.)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
\$0 co-pay for Medicaid-covered services.

General

\$0 co-pay for Medicare-covered urgently-needed-care visits*
If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.

Outpatient Rehabilitation Services

(Occupational Therapy, Physical Therapy, Speech and Language Therapy)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
\$0 co-pay for Medicaid-covered services.

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered Occupational Therapy visits*
\$0 co-pay for Medicare-covered Physical and/or Speech and Language Therapy visits*

Outpatient Medical Services and Supplies

Durable Medical Equipment
(includes wheelchairs, oxygen, etc.)

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
\$0 co-pay for Medicaid-covered services.

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered items*

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Outpatient Medical Services and Supplies****Prosthetic Devices**

(includes braces, artificial limbs and eyes, etc.)

For dual-eligible members Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
\$0 co-pay for Medicaid-covered services.

General

Authorization rules may apply.

In-Network

\$0 co-pay for Medicare-covered items*

Diabetes Programs and Supplies

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.

General

Authorization rules may apply.

In-Network

\$0 co-pay for diabetes self-management training*

\$0 co-pay for:

- Diabetes monitoring supplies*
- Therapeutic shoes or inserts*

Diagnostic Tests, X-Rays, Lab Services, and Radiology Services

For dual-eligible members, Medicaid pays for this service

General

Authorization rules may apply.

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Outpatient Medical Services and Supplies**

Diagnostic Tests, X-Rays, Lab Services, and Radiology Services

if it is not covered by Medicare or when the Medicare benefit is exhausted.
 \$0 co-pay for Medicaid-covered services.

In-Network

- \$0 co-pay for Medicare-covered:
- Lab services*
 - Diagnostic procedures and tests*
 - X-rays*
 - Diagnostic radiology services (not including X-rays)*
 - Therapeutic radiology services*

Preventive Services

Cardiac and Pulmonary Rehabilitation Services

Not covered.

General

Authorization rules may apply.

In-Network

- \$0 co-pay for:
- Medicare-covered Cardiac Rehabilitation Services*
 - Medicare-covered Intensive Cardiac Rehabilitation Services*
 - Medicare-covered Pulmonary Rehabilitation Services*

Preventive Services and Wellness/Education Programs

For dual-eligible members, Medicaid pays for these services if they are not covered by Medicare or when the Medicare benefit is exhausted.

- Bone Mass Measurement
- Colorectal Screening Exams

General

\$0 co-pay for all preventive services covered under Original Medicare at zero cost sharing:

- Abdominal Aortic Aneurysm screening
- Bone Mass Measurement
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Preventive Services****Preventive Services and Wellness/Education Programs**

- Immunizations (Flu vaccine, Hepatitis B vaccine for people with Medicare at risk, & Pneumococcal vaccine)
- Mammograms (Annual Screening)
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Welcome to Medicare and Annual Wellness Visit

\$0 co-pay for Medicaid-covered services.

Health/Wellness Education

- Written health education materials, including newsletters
- Nutritional training
- Additional smoking cessation
- Other wellness benefits

Medicaid does not pay for educational services. Medicaid provides coverage for medically necessary nutritional counseling in an outpatient hospital setting and also provides coverage for smoking

- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine
- HIV Screening
- Breast Cancer Screening (Mammogram)
- Medical Nutrition Therapy Services
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine
- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
- Smoking Cessation (Counseling to stop smoking)
- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

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.

In-Network

The plan covers the following supplemental education/wellness programs:

- Written health education materials, including newsletters
- Health Club Membership/Fitness Classes
- Nursing Hotline

BENEFIT

MEDICAID

WELLCARE ACCESS (HMO SNP)

<p>Preventive Services</p>	<p>cessation counseling services for pregnant women in multiple settings. Education and educational materials are not a covered service. \$0 co-pay for Medicaid-covered services.</p>	
<p>Kidney Disease and Conditions</p>	<p>For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>In-Network \$0 co-pay for renal dialysis* \$0 co-pay for kidney disease education services*</p>
<p>Outpatient Prescription Drugs</p>	<p>For dual-eligible members, Medicaid will not pay for Medicare Part D non-formulary medications. The exception to this rule is Medicare Part D excluded drugs (i.e., benzodiazepines and barbiturates), which will</p>	<p>Drugs covered under Medicare Part B General \$0 annual deductible for Part B-covered drugs.* \$0 co-pay for Part B covered chemotherapy drugs and other Part-B covered drugs.* Drugs covered under Medicare Part D</p>

BENEFIT

MEDICAID

WELLCARE ACCESS (HMO SNP)

Preventive Services

Outpatient Prescription Drugs

continue to be covered by Medicaid.

All dual eligible clients are financially responsible for the first fifteen dollars (\$15.00) of co-pays imposed by their Medicare Part D plan every month. Once the client's co-pay amount exceeds fifteen dollars in a given month, any co-pays incurred thereafter will be covered by CT Medicaid and the client will have a \$0 co-pay.

General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.wellcare.com on the Web.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service) providers.

The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from WellCare Access (HMO SNP) for certain drugs.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Preventive Services****Outpatient Prescription Drugs**

website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and WellCare Access (HMO SNP) approves the exception, you will pay the generic cost share for generic drugs and the brand cost share for brand drugs.

In-Network

You pay a \$0 annual deductible.

Initial Coverage

Depending on your income and institutional status, you pay the following:

You pay \$0 co-pay for Tier 1 drugs until you reach the initial coverage limit of \$2,930 in total drug spend. Then depending on your income and institutional status, you pay the following for Tier 1 drugs:

- A \$0 (generic and brand) co-pay; or
- A \$1.10 (generic) or \$3.30 (brand) co-pay or
- A \$2.60 (generic) or \$6.50 (brand) co-pay

For Tier 2, 3, or 4 drugs, you pay the following co-pays depending on your income and institutional status until you reach the out of pocket threshold of \$4,700.

- A \$0 co-pay (generic and brand); or

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Preventive Services****Outpatient Prescription Drugs**

- A \$1.10 (generic) or \$3.30 (brand) co-pay or
 - A \$2.60 (generic) or \$6.50 (brand) co-pay
- All co-pays count towards your initial coverage limit and out of pocket threshold.

Catastrophic Coverage

You pay a \$0 co-pay.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from WellCare Access (HMO SNP).

Out-of-Network Initial Coverage

Depending on your income and institutional status, you pay the following:

You pay \$0 co-pay for Tier 1 drugs until you reach the initial coverage limit of \$2,930 in total drug spend. Then depending on your income and institutional status, you pay the following for Tier 1 drugs:

- A \$0 (generic and brand) co-pay; or
- A \$1.10 (generic) or \$3.30 (brand) co-pay or
- A \$2.60 (generic) or \$6.50 (brand) co-pay

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Preventive Services****Outpatient Prescription Drugs**

For Tier 2, 3, or 4 drugs, you pay the following co-pays depending on your income and institutional status until you reach the out of pocket threshold of \$4,700.

- A \$0 co-pay (generic and brand); or
- A \$1.10 (generic) or \$3.30 (brand) co-pay or
- A \$2.60 (generic) or \$6.50 (brand) co-pay

All co-pays count towards your initial coverage limit and out of pocket threshold.

Out-of-Network Catastrophic Coverage

You will be reimbursed in full for drugs purchased out-of-network.

Dental Services

The following Dental Services are a benefit of Connecticut Medicaid.

Medicaid provides comprehensive dental care for children and adults. These services are covered benefits when the dentist participates with the Connecticut Dental Health Partnership network.

Covered Dental Services:

- Cleanings
- Complete Dentures
- Crowns
- Examinations

General

Authorization rules may apply.

In-Network

- \$0 co-pay for Medicare-covered dental benefits*
- \$0 co-pay for up to 1 oral exam(s) every six months
- \$0 co-pay for up to 1 cleaning(s) every six months
- \$0 co-pay for up to 1 dental X-ray(s)

BENEFIT

MEDICAID

WELLCARE ACCESS (HMO SNP)

Preventive Services

Dental Services

- Extractions
- Fillings (silver amalgam and white composite)
- Oral Surgery
- Partial Dentures
- Root Canal Treatment
- X-Rays

Additional Covered Dental Services for Children Include:

- Fluoride treatments for children ages 1–21
- Orthodontia (braces)
- Sealants for children ages 5–16

Service Limitations

- Dentures are covered only one time for every seven-year period
- Fixed bridgework is not a covered benefit
- Dental implants of any type are not a covered benefit
- Porcelain crowns are limited to anterior teeth

Preventive Services

Dental Services

- Orthodontia (braces) is limited to children whose teeth are sufficiently crooked that a score of 24 points or greater is achieved on the Salzmann Scale
- Periodontal services are not a covered benefit
- Root canal treatment is not performed when there are multiple missing teeth or the outcome is poor
- Sealants are replaced only one time for every five-year period

Covered Services That Require

Prior Authorization:

- Apexification
- Replacement of complete dentures
- Surgical extractions
- Oral surgery for facial deformities
- Orthodontia (braces)
- Placement of partial dentures
- Replacement of retainer for orthodontia

BENEFIT

MEDICAID

WELLCARE ACCESS (HMO SNP)

Preventive Services

Dental Services

- Re-treatment of a tooth with previous root canal therapy
- \$0 co-pay for Medicaid-covered services.

Hearing Services

The following hearing services are a benefit of Connecticut Medicaid.

Hearing services and products when medically necessary to alleviate disability caused by loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing; and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aids, ear molds, special fittings and replacement parts.

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.

In-Network

- 0% of the cost for up to 1 supplemental routine hearing exam(s) every year
 - 0% of the cost for up to 1 hearing aid fitting-evaluation(s) every three years
 - \$0 co-pay for up to 1 hearing aid(s) every three years
- \$50 plan coverage limit for supplemental routine hearing exams every year.

\$350 plan coverage limit for hearing aids every three years.

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Preventive Services****Hearing Services**

\$0 co-pay for Medicaid-covered services.

Vision Services

The following vision services are a benefit of Connecticut Medicaid.

Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage includes the repair of broken eyeglasses. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease.

Examinations for refraction are limited to once per year unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than one (1) pair, once per two years unless medically necessary due to a significant change in vision. No

In-Network

- 0% of the cost for up to 1 supplemental routine eye exam(s) every year
 - \$0 co-pay for up to 1 pair(s) of glasses every year
 - \$0 co-pay for up to 1 pair(s) of contacts every year
 - \$0 co-pay for up to 1 pair(s) of lenses every year
 - \$0 co-pay for up to 1 frame(s) every year
- \$100 plan coverage limit for eye wear every year.

Preventive Services

Vision Services

prerequisite of cataract services.
 For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.
 \$0 co-pay for Medicaid-covered services.

Over-the-Counter Items

Not covered.

General

Please visit our plan website to see our list of covered Over-the-Counter items.
 OTC items may be purchased only for the enrollee.
 Please contact the plan for specific instructions for using this benefit.

Transportation
(Routine)

The following transportation services are a benefit of Connecticut Medicaid.

Transportation essential for an enrollee to obtain necessary medical care services. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means

In-Network

\$0 co-pay for up to 20 one-way trip(s) to plan approved location every year

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Preventive Services****Transportation
(Routine)**

appropriate to the enrollee's medical condition.

Mileage reimbursement for family members driving to an appointment. This benefit is only available in certain circumstances if no other means of transportation is available.

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.

\$0 co-pay for Medicaid-covered services.

Acupuncture

Not covered.

In-Network

This plan does not cover Acupuncture.

Family Planning

The following family planning services are a benefit of Connecticut Medicaid.

The department shall pay for family planning that may include: abortion and hysterectomy services; Early and Periodic Screening,

Not covered.

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO SNP)****Preventive Services****Family Planning**

Diagnostic and Treatment services; family planning services for clients of childbearing age.

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.

\$0 co-pay for Medicaid-covered services.

Natureopath

The following natureopath services are a benefit of Connecticut Medicaid.

The department shall pay for the professional services of a licensed natureopath which conform to accepted methods of diagnosis and treatment.

For dual-eligible members, Medicaid will pay for the coinsurance where Medicare pays as primary.

\$0 co-pay for Medicaid-covered services.

Not covered.

BENEFIT

MEDICAID

WELLCARE ACCESS (HMO SNP)

Preventive Services

Targeted Case Management

The following targeted case management services are a benefit of Connecticut Medicaid.

Case management services may include a continuum of supportive activities performed by an individual case manager which enable an eligible person to gain access to needed services. Case management services can include one or more of the following types of case management activities in a calendar quarter:

Case advocacy, collaboration, coordinating or attending team meetings, coordination of a plan of services, monitoring the quality and quantity, providing information and referral, and review and maintenance of an eligible person's plan of services.

For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare

Not covered.

BENEFIT

MEDICAID

WELLCARE ACCESS (HMO SNP)

Preventive Services

Targeted Case Management

or when the Medicare benefit is exhausted.
\$0 co-pay for Medicaid-covered services.



WellCare Health Plans, Inc. has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2014. NCQA's approval is based on a review of WellCare's Model of Care and is an indicator of compliance with CMS requirements.

NCQA's approval is not an endorsement by CMS and/or NCQA of WellCare or the quality of service provided by WellCare. WellCare will still need to be approved each year by CMS in order to operate. If you have questions regarding our approval by the NCQA, please contact us at 1-866-635-7047.



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Monday - Sunday, 8am to 9pm Eastern

Medicare_{Rx}
Prescription Drug Coverage

38669