



Summary of Benefits

—— Coordinated Care Plans ——



Connecticut

Fairfield, Hartford, New Haven, and Tolland Counties

WellCare of Connecticut, Inc. | H0712

01/01/12 - 12/31/12

Wellcare Value (HMO) | Plan 019



Section I - Introduction to Summary of Benefits

Thank you for your interest in Wellcare Value (HMO). Our plan is offered by WellCare of Connecticut, Inc./WellCare, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Wellcare Value (HMO) 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 Value (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Wellcare Value (HMO) at the telephone 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 Value (HMO) 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 Value (HMO) 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 Value (HMO)?

You can join Wellcare Value (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Wellcare Value (HMO) unless they are members of our organization and have been since their dialysis began.

Can I choose my doctors?

Wellcare Value (HMO) 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.

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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 Value (HMO) 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 Value (HMO) 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 Value (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What is a prescription drug formulary?

Wellcare Value (HMO) 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.

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.

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- 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 Value (HMO), 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.

As a member of Wellcare Value (HMO), 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.

Section I - Introduction to Summary of Benefits

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 Value (HMO) 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 Value (HMO) 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.

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 Value (HMO).



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)-579-8006 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 019

BENEFIT	ORIGINAL MEDICARE	WELLCARE VALUE (HMO)
<p>1 Premium and Other Important Information</p>	<p>In 2011 the monthly Part B Premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE</p>	<p>General</p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network</p> <p>\$4,900 out-of-pocket limit for Medicare-covered services.</p>

BENEFIT**ORIGINAL MEDICARE****WELLCARE VALUE (HMO)****Important Information****1** Premium and Other Important Information

(1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

2 Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)

You may go to any doctor, specialist or hospital that accepts Medicare.

In-Network

You must go to network doctors, specialists, and hospitals. Referral required for network specialists (for certain benefits).

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

In 2011 the amounts for each benefit period were:

- Days 1 - 60: \$1132 deductible
- Days 61 - 90: \$283 per day
- Days 91 - 150: \$566 per lifetime reserve day.

These amounts may change for 2012.

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

Lifetime reserve days can only be used once.

In-Network

No limit to the number of days covered by the plan each hospital stay.

For Medicare-covered hospital stays:

- Days 1 - 5: \$320 co-pay per day
- Days 6 - 90: \$0 co-pay per day

\$0 co-pay for additional hospital days

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

BENEFIT**ORIGINAL MEDICARE****WELLCARE VALUE (HMO)****Inpatient Care****3 Inpatient Hospital Care**
(includes Substance Abuse and Rehabilitation Services)

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. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

4 Inpatient Mental Health Care

In 2011 the amounts for each benefit period were:

- Days 1 - 60: \$1132 deductible
- Days 61 - 90: \$283 per day
- Days 91 - 150: \$566 per lifetime reserve day.

These amounts may change for 2012.

You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day

In-Network

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.

For Medicare-covered hospital stays:

- Days 1 - 4: \$320 co-pay per day
- Days 5 - 90: \$0 co-pay per day

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

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

lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

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

In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were:

- Days 1 - 20: \$0 per day
- Days 21 - 100: \$141.50 per day

These amounts may change for 2012.

100 days for each benefit period.

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.

General

Authorization rules may apply.

In-Network

Plan covers up to 100 days each benefit period

No prior hospital stay is required.

For SNF stays:

- Days 1 - 20: \$0 co-pay per day
- Days 21 - 100: \$146 co-pay per day

BENEFIT

ORIGINAL MEDICARE

WELLCARE VALUE (HMO)

Inpatient Care

<p>5 Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	
<p>6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 co-pay</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for each Medicare-covered home health visit</p>
<p>7 Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>
<p>Outpatient Care</p>		
<p>8 Doctor Office Visits</p>	<p>20% coinsurance</p>	<p>In-Network \$10 co-pay for each primary care doctor visit for Medicare-covered benefits. \$35 co-pay for each in-area, network urgent care Medicare-covered visit \$35 co-pay for each specialist visit for Medicare-covered benefits.</p>

BENEFIT

ORIGINAL MEDICARE

WELLCARE VALUE (HMO)

Outpatient Care

9 Chiropractic Services

Supplemental routine care not covered
 20% coinsurance 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.

In-Network

\$20 co-pay for each Medicare-covered visit

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.
 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.

In-Network

\$35 co-pay for each Medicare-covered visit

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

11 Outpatient Mental Health Care

40% coinsurance for most outpatient mental health services
 Specified co-payment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Co-pay cannot exceed the Part A inpatient hospital deductible.

General

Authorization rules may apply.

In-Network

\$35 co-pay for each Medicare-covered individual therapy visit
 \$25 co-pay for each Medicare-covered group therapy visit
 \$35 co-pay for each Medicare-covered individual therapy visit with a psychiatrist
 \$25 co-pay for each Medicare-covered group therapy visit with a psychiatrist

BENEFIT

ORIGINAL MEDICARE

WELLCARE VALUE (HMO)

Outpatient Care

11 Outpatient Mental Health Care

"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.

\$320 co-pay for Medicare-covered partial hospitalization program services

12 Outpatient Substance Abuse Care

20% coinsurance

General
Authorization rules may apply.

In-Network

\$35 co-pay for Medicare-covered individual visits
\$25 co-pay for Medicare-covered group visits

13 Outpatient Services/Surgery

20% coinsurance for the doctor's services
Specified co-payment for outpatient hospital facility services. Co-pay cannot exceed the Part A inpatient hospital deductible.
20% coinsurance for ambulatory surgical center facility services

General
Authorization rules may apply.

In-Network

\$75 co-pay for each Medicare-covered ambulatory surgical center visit
\$0 to \$200 co-pay for each Medicare-covered outpatient hospital facility visit

BENEFIT**ORIGINAL MEDICARE****WELLCARE VALUE (HMO)****Outpatient Care**

14 Ambulance Services
(medically necessary ambulance services)

20% coinsurance

General

Authorization rules may apply.

In-Network

\$125 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.)

20% coinsurance for the doctor's services
Specified co-payment for outpatient hospital facility emergency services.

General

\$65 co-pay for Medicare-covered emergency room visits
Worldwide coverage.

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

Emergency services co-pay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.

You don't have to pay the emergency room co-pay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.

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

BENEFIT

ORIGINAL MEDICARE

WELL-CARE VALUE (HMO)

Outpatient Care

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

20% coinsurance, or a set co-pay
NOT covered outside the U.S. except under limited circumstances.

General
\$35 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)

20% coinsurance

General
Authorization rules may apply.

In-Network

\$35 co-pay for Medicare-covered Occupational Therapy visits
\$35 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.)

20% coinsurance

General
Authorization rules may apply.

In-Network

20% of the cost for Medicare-covered items

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

20% coinsurance

General
Authorization rules may apply.

BENEFIT

ORIGINAL MEDICARE

WELLCARE VALUE (HMO)

Outpatient Medical Services and Supplies

<p>19 Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p> <p>20 Diabetes Programs and Supplies</p>	<p>20% coinsurance for diabetes self-management training</p> <p>20% coinsurance for diabetes supplies</p> <p>20% coinsurance for diabetic therapeutic shoes or inserts</p>	<p>In-Network 20% of the cost for Medicare-covered items</p> <p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for diabetes self-management training 0% of the cost for diabetes monitoring supplies 20% of the cost for Therapeutic shoes or inserts</p>
<p>21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>20% coinsurance for diagnostic tests and X-rays</p> <p>\$0 co-pay for Medicare-covered lab services</p> <p>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.</p> <p>In-Network \$0 to \$200 co-pay for Medicare-covered lab services \$20 to \$200 co-pay for Medicare-covered diagnostic procedures and tests \$0 to \$200 co-pay for Medicare-covered X-rays \$100 to \$200 co-pay for Medicare-covered diagnostic radiology services (not including X-rays) \$35 co-pay for Medicare-covered therapeutic radiology services</p>

BENEFIT**ORIGINAL MEDICARE****WELLCARE VALUE (HMO)****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.

20% coinsurance for 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

20% coinsurance Cardiac Rehabilitation services.

20% coinsurance for Pulmonary Rehabilitation services.

20% 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

\$35 to \$200 co-pay for Medicare-covered Cardiac Rehabilitation Services

\$35 to \$200 co-pay for Medicare-covered Intensive Cardiac Rehabilitation Services

\$35 to \$200 co-pay for Medicare-covered Pulmonary Rehabilitation Services

BENEFIT

ORIGINAL MEDICARE

WELLCARE VALUE (HMO)

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 VALUE (HMO)

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 VALUE (HMO)

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 VALUE (HMO)

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 VALUE (HMO)

Preventive Services

24 Kidney Disease and Conditions

20% coinsurance for renal dialysis
20% coinsurance for kidney disease education services

In-Network

20% of the cost for renal dialysis
20% of the cost 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

20% of the cost 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 VALUE (HMO)

Preventive Services

25 Outpatient Prescription Drugs

Total yearly drug costs are the total drug costs paid by both you and a Part D plan.

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 Value (HMO) 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 Value (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.

In-Network

\$0 deductible.

Initial Coverage

You pay the following until total yearly drug costs reach \$2,930:

BENEFIT**ORIGINAL MEDICARE****WELL CARE VALUE (HMO)**

Preventive Services

25 Outpatient Prescription Drugs**Retail Pharmacy**

Tier 1: Generic Drugs

- \$5 co-pay for a one-month (31-day) supply of drugs in this tier
- \$15 co-pay for a three-month (93-day) supply of drugs in this tier

Tier 2: Preferred Brand Drugs

- \$45 co-pay for a one-month (31-day) supply of drugs in this tier
- \$135 co-pay for a three-month (93-day) supply of drugs in this tier

Tier 3: Non-Preferred Brand Drugs

- \$89 co-pay for a one-month (31-day) supply of drugs in this tier
- \$267 co-pay for a three-month (93-day) supply of drugs in this tier

Tier 4: Specialty Tier Drugs

- 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Long Term Care Pharmacy

Tier 1: Generic Drugs

- \$5 co-pay for a one-month (31-day) supply of drugs in this tier

Tier 2: Preferred Brand Drugs

- \$45 co-pay for a one-month (31-day) supply of drugs in this tier

Preventive Services

25 Outpatient Prescription Drugs

Tier 3: Non-Preferred Brand Drugs

- \$89 co-pay for a one-month (31-day) supply of drugs in this tier

Tier 4: Specialty Tier Drugs

- 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Mail Order

Tier 1: Generic Drugs

- \$5 co-pay for a one-month (31-day) supply of drugs in this tier from a preferred mail order pharmacy.
- \$12.50 co-pay for a three-month (93-day) supply of drugs in this tier from a preferred mail order pharmacy.
- \$15 co-pay for a three-month (93-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

Tier 2: Preferred Brand Drugs

- \$45 co-pay for a one-month (31-day) supply of drugs in this tier from a preferred mail order pharmacy.
- \$112.50 co-pay for a three-month (93-day) supply of drugs in this tier from a preferred mail order pharmacy.
- \$135 co-pay for a three-month (93-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

Tier 3: Non-Preferred Brand Drugs

- \$89 co-pay for a one-month (31-day) supply of drugs in this tier from a preferred mail order pharmacy.
- \$222.50 co-pay for a three-month (93-day) supply of drugs in this tier from a preferred mail order pharmacy.
- \$267 co-pay for a three-month (93-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

Preventive Services

25 Outpatient Prescription Drugs

- Tier 4: Specialty Tier Drugs
- 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred mail order pharmacy.
 - 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

Coverage Gap

After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:

- 5% coinsurance, or
- \$2.60 co-pay for generic (including brand drugs treated as generic) and a \$6.50 co-pay for all other 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 Value (HMO).

Preventive Services

25 Outpatient Prescription Drugs

Out-of-Network Initial Coverage

You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:

Tier 1: Generic Drugs

- \$5 co-pay for a one-month (31-day) supply of drugs in this tier

Tier 2: Preferred Brand Drugs

- \$45 co-pay for a one-month (31-day) supply of drugs in this tier

Tier 3: Non-Preferred Brand Drugs

- \$89 co-pay for a one-month (31-day) supply of drugs in this tier

Tier 4: Specialty Tier Drugs

- 33% coinsurance for a one-month (31-day) supply of drugs in this tier

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Additional Out-of-Network Coverage Gap

You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.

You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.

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

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:

- 5% coinsurance, or
- \$2.60 co-pay for generic (including brand drugs treated as generic) and a \$6.50 co-pay for all other drugs.

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

26 Dental Services

Preventive dental services (such as cleaning) not covered.

General

Authorization rules may apply.

In-Network

In general, preventive dental benefits (such as cleaning) not covered.

\$0 co-pay for Medicare-covered dental benefits

BENEFIT**ORIGINAL MEDICARE****WELLCARE VALUE (HMO)****Preventive Services****27 Hearing Services**

Supplemental routine hearing exams and hearing aids not covered.
 20% coinsurance for diagnostic hearing exams.

In-Network

- \$35 co-pay for Medicare-covered diagnostic hearing exams
- \$0 co-pay for up to 1 supplemental routine hearing exam(s) every year
- \$0 co-pay 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.

28 Vision Services

20% 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 co-pay for one pair of eyeglasses or contact lenses after cataract surgery.
- \$0 to \$35 co-pay for exams to diagnose and treat diseases and conditions of the eye.
- \$0 co-pay for up to 1 supplemental routine eye exam(s) 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.

BENEFIT**ORIGINAL MEDICARE****WELLCARE VALUE (HMO)****Preventive Services****Over-the-Counter Items**

Please contact the plan for specific instructions for using this benefit.

**Transportation
(Routine)**

Not covered.

In-Network

This plan does not cover supplemental routine transportation.

Acupuncture

Not covered.

In-Network

This plan does not cover Acupuncture.



127 Washington Avenue East Building, 4th Floor | North Haven, CT 06473

www.wellcare.com | (866)-579-8006

TTY/TDD: (877)-247-6272

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