
Introduction

The Plan provides managed care services exclusively for government-sponsored health care programs, focusing on Medicaid and Medicare Advantage plans.

Headquartered in Tampa, Florida, WellCare offers a variety of Medicaid and Medicare Advantage plans, including health plans for families, children, the aged, blind and disabled, and prescription drug plans, currently serving more than 2.27 million members nationwide.

Core Values**Partnership**

Members are the reason we are in business; Providers are our partners in serving our members; and regulators are the stewards of the public's resources and trust. We will deliver excellent service to our partners.

Integrity

Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.

Accountability

All associates must be responsible for the commitments we make and the results we deliver.

Teamwork

With our fellow associates, we can expect – and are expected to demonstrate – a collaborative approach in the way we work.

**WellCare
(Medicare
Advantage)**

As a Medicare Advantage plan, coverage includes all of the benefits traditionally covered by Medicare plus added benefits identified in coverage documents.

Such additional benefits may include*:

WellCare Health Plans, Inc. (WellCare) is the parent company to the following existing and applicant subsidiaries: WellCare of Florida, Inc., HealthEase of Florida, Inc., WellCare of New York, Inc., WellCare of Connecticut, Inc., WellCare of Louisiana, Inc., WellCare of Georgia, Inc., WellCare of Ohio, Inc., WellCare of Texas, Inc., WellCare Health Plans of New Jersey, Inc., WellCare of South Carolina, Inc., Harmony Behavioral Health, Inc., Harmony Health Plan of Illinois, Inc., Harmony Health Plan of Indiana, Inc., WellCare Prescription Insurance, Inc., WellCare Health Insurance of Arizona, Inc., WellCare Health Insurance of Illinois, Inc., and WellCare Health Insurance of New York, Inc.

- No or low monthly health plan premiums with predictable co-pays for in-network services;
- Outpatient prescription drug coverage, including Tier 1 drugs through the coverage gap;
- Routine dental, vision and hearing benefits; and
- Preventive care from participating providers with no co-payment.

**Subject to change. Availability varies by plan and county.*

Our Products

Our products are designed to offer enhanced benefits to our members as well as cost sharing alternatives. Additional HMO plan options available in select areas in 2008 include the Point-of-Service (POS) and the Concentric Network options. In addition, a Preferred Provider Organization (PPO) plan is available in select areas in 2008. These products are offered in selected markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area. Please refer to the state-specific **Quick Reference Guide** for product information. Below is a list of distinctions (not all-inclusive) among our Medicare Advantage products.

HMO

Our traditional Medicare Advantage plan. All services must be provided within the Plan network unless an emergency or urgent need for care arises, or such service is not available in network. Some services require prior authorization by the Plan, or its designee.

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HMO with POS Option (HMO/POS)

Members may choose to visit out-of-network providers for selected specialty, ancillary, and hospital services. Out-of-network services may require authorization by the Plan. Member cost share for covered out-of-network services is a coinsurance or percentage of the payment made by the Plan.

HMO/POS with Concentric Network

Available in selected markets only. Members have access to expanded benefits not traditionally covered by Medicare. Members must choose a Primary Care Physician (PCP) from a subset of the Plan network PCPs. Some services require authorization by the Plan.

PPO

Allows members to visit in-network or out-of-network providers for covered services. Some in-network services require authorization by the Plan. Out-of-network services do not. However, notification to the Plan is recommended for verification of benefits or when emergency care was needed. Member cost share for out-of-network services is a coinsurance or percentage of the payment made by the Plan.

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