



WellCare
has changed
its Medicare
benefit offerings
for your patients
in 2009.

Your knowledge of
these services can
improve their health
and lifestyle. Turn
the page for a brief
overview of our
Point-of-Service
(POS) option.





It's about offering our members the choice to see the doctors they prefer.

You are a key participant in this option.

Many of our core MAPD plans include a **Point-of-Service (POS) option** allowing members out-of-network access for select covered services.

Every member of an eligible MAPD plan can exercise the POS option, with your approval.

There is no rider to choose or extra premium for the member to pay. However, the member's out-of-pocket costs will be higher when they use the POS option for out-of-network services.

The POS option is available within selected MAPD core plans only.

What the POS option means to WellCare's Medicare members:

- Some covered services may be obtained out of network (Refer to the Member Evidence of Coverage for a listing of covered services).
- Services not covered out of network by the POS option:
 - > Primary care & physical exams
 - > Part B drugs
 - > Part D drugs
 - > Acupuncture
 - > Transportation
 - > Dental, vision & hearing
 - > Over-the-Counter (OTC) items
- Members pay more to access services out of the Plan's network of providers (except in case of emergency).
- Members' PCPs must be in the Plan's network of providers.

Currently, PCPs may refer patients out-of-network to access a specific type of provider or while transitioning care for patients new to the Plan. In these situations, services are covered at the HMO (in-network benefit level). Using our standard WellCare authorization process, our POS OPTION allows patients the choice of going out-of-network to see their preferred specialized providers for medically necessary care. The POS (out-of-network) benefit requires greater cost-sharing by the patient.

What the POS option means to WellCare's primary care providers (PCPs):

- You are the “medical home” for our members. You coordinate care by requesting authorization from the Plan for out-of-network services when requested by the patient.
- Authorization is **required** for any service obtained out of the Plan's network. The authorization process informs us of your consent for the member to access out-of-network services and let us know who will reach out to us for claim payment. We review all authorizations for medical necessity and would only deny a request if the service is not a covered benefit.
- In-network services are managed using existing guidelines as per the Quick Reference Guide and Provider Manual.

About the POS Option

What is the Medicare Advantage Point-of-Service (POS) option?	An HMO plan with a Point of Service (POS) benefit that allows members to access some—but not all—covered services out of the Plan’s network of providers.
Do patients need to elect the POS option when enrolling in the Plan?	No. The POS option is an integrated benefit, which means that every member of an eligible MAPD plan automatically gets the POS option. There is no rider to choose or extra premium for the member to pay to get the POS option.
Where is the POS option available?	The POS option is available within selected MAPD core plans in selected states and counties only. Contact your Provider Relations representative for county and Plan listings in your area.

PCP Critical Questions

How will the POS option affect me?	Your patients may inquire about accessing out-of-network providers using their POS option. If so, we ask that you coordinate an authorization through the Plan if the service is a covered benefit.
What are my responsibilities?	PCPs will continue to be the “medical home” for our members and will continue to coordinate care with the Plan and other providers as is standard practice. However, with the POS option, members may also request PCP assistance in requesting an authorization from the Plan to visit an out-of-network provider.
How do I know if a patient has the POS option?	When patients have the POS option, the front of their WellCare ID card will state “HMO with a POS OPTION”. The back of their WellCare ID card will also state (i) the member’s coinsurance for covered out-of-network health services; (ii) that prior authorization is required; and (iii) that Medicare limiting charges apply.
What if I do not agree with a patient’s request for out-of-network services under the POS option?	We encourage you to work with your patients in facilitating their health care needs. Ultimately, it is your patients’ choice whether to use their POS benefit. If you do not agree with a patient’s request for services—in or out of network—contact the Plan so we can notify the member.

Authorization-Related Critical Questions

Which services require an authorization?	Authorization is required for any service obtained out of the Plan's network.
How do I find a list of services that need authorization?	Refer to your Quick Reference Guide for authorization guidelines in or out of network and contact information. (In-network authorization requirements may differ by state.)
What if the Plan denies an out-of-network authorization request?	The Plan would only deny authorization of out-of-network care for non-covered services.

Patient Critical Questions

What should patients know before using their POS option?	<p>They will be responsible for greater cost-sharing, which may be as high as 20 to 30 percent, depending on their plan.</p> <p>Patients' coinsurance for covered services under the POS option will be a percentage of the amount approved by Original Medicare. Patients may be subject to balance billing when they see out-of-network providers who do not accept the amount approved by Original Medicare as payment in full.</p>
Can patients choose an out-of-network PCP under the POS option?	No, the POS option does not cover primary care services from PCPs not participating in the Plan's network of providers.
Does the POS option allow patients to self-refer out of network?	No, all services covered out of network under the POS option require an authorization by the Plan, which must be coordinated through the patient's PCP.
What if the patient has to use an out-of-network (OON) provider because an in-network provider is not available to render the service?	The patient does <i>not</i> have to meet the POS coinsurance obligation. Rather, the standard in-network co-pay amounts apply. This is also true for transition of care and any other time when the choice to use an OON provider is driven by WellCare's policies and procedures or contract with CMS.

