



# 2026 Summary of Benefits

## New Jersey

### **Wellcare Giveback (HMO-POS)**

H0913 | 021 | 000

### **Wellcare Simple (HMO-POS)**

H0913 | 022 | 000

### **Wellcare Assist (HMO-POS)**

H0913 | 015 | 000

**We know how important it is to have a health plan you can count on.**

This is a summary of drug and health services covered by Wellcare Giveback (HMO-POS), Wellcare Simple (HMO-POS) and Wellcare Assist (HMO-POS) from January 1, 2026 to December 31, 2026.

This booklet will provide you with a summary of what we cover and what you pay. It does not list every service, limitation, or exclusion. A complete list of services can be found in the plan's Evidence of Coverage (EOC). You can find the Evidence of Coverage on our website at [go.wellcare.com/Medicare](https://go.wellcare.com/Medicare). To request a copy, please call 1-844-480-0680 (TTY 711). Hours are: Sunday-Saturday, 8 am to 8 pm.

**Who can join?**

To join these plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and be a United States citizen or lawfully present in the United States. You must continue to pay your Medicare Part B premium if not otherwise paid for under New Jersey Family Care (Medicaid) or by another third party.

**Plan's service areas:**

**H0913021000 Wellcare Giveback (HMO-POS)** includes these counties in New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren.

**H0913022000 Wellcare Simple (HMO-POS)** includes these counties in New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren.

**H0913015000 Wellcare Assist (HMO-POS)** includes these counties in New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren.

**About this plan & how to get care**

**Health Maintenance Organizations (HMOs)** are health care plans offered by an insurance provider with a network of contracted healthcare providers and facilities. HMOs generally require members to select a primary care provider (PCP) to coordinate care and if you need a specialist, the PCP will choose one who is also in our network.

**Health Maintenance Organizations-Point of Service (HMO-POS)** plans are HMOs with the Point-of-Service (POS) benefit. The POS benefit allows members to get care from out-of-network providers for routine dental services as shown in the "Benefits" section of this document. Your out-of-pocket costs may be higher if you use out-of-network providers. You don't need a referral to go out-of-network for your POS benefit. However, before getting services from out-of-network providers, you may want to confirm with us that the services are covered by us. If we later determine that the services are not covered, we may deny coverage and you will have to pay the costs. Please call our

Member Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Our plans give you access to our network of skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. **Please note** that, if you go elsewhere without proper authorization, you will have to pay in full. Neither Medicare nor our plan will be responsible for the costs. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Wellcare Giveback (HMO-POS), Wellcare Simple (HMO-POS) and Wellcare Assist (HMO-POS) authorizes use of out-of-network providers.

**Part D prescription drugs** are covered. You have access to our large network of pharmacies. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. Our plans use a *formulary*. Our drug plans are designed specifically for Medicare beneficiaries and include a comprehensive selection of affordable generic and brand name drugs.

**Which doctors, hospitals and pharmacies can I use?** Wellcare Giveback (HMO-POS), Wellcare Simple (HMO-POS) and Wellcare Assist (HMO-POS) have a network of doctors, hospitals, pharmacies, and other providers. You may use out-of-network providers for routine dental services. For all other services, you must use providers that are within our network, or the plan may not pay for the service.

You can save money by using our preferred mail-order pharmacy and by using providers in the plan's network. You can see our plan's provider and pharmacy directory at [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories). Our complete plan Formulary (list of Part D prescription drugs) is on our website at H0913021000 Wellcare Giveback (HMO-POS): [go.wellcare.com/druglist-6718](https://go.wellcare.com/druglist-6718); H0913022000 Wellcare Simple (HMO-POS): [go.wellcare.com/druglist-6718](https://go.wellcare.com/druglist-6718); H0913015000 Wellcare Assist (HMO-POS): [go.wellcare.com/druglist-6712](https://go.wellcare.com/druglist-6712).

We cover the services and items in this document and the Evidence of Coverage if they are medically necessary.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

We must provide information in a way that works for you (in languages other than English, in audio, in braille, in large print, or other alternate formats, etc.). For more information, or to request information in an alternate format, please call us at 1-844-480-0680 (TTY users should call 711). Hours are: Sunday-Saturday, 8 am to 8 pm.

## Benefits

|                                                                                                                                             | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                 | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                   | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <b>Note:</b> Services with an asterisk (*) may require prior authorization.<br>Services with a square (■) means a referral may be required. |                                                                                                                     |                                                                                                                     |                                                                                                                     |
| <b>Monthly Plan Premium</b><br>(includes both medical and drugs)                                                                            | \$0<br><br>You must continue to pay your Medicare Part B premium.                                                   | \$0<br><br>You must continue to pay your Medicare Part B premium.                                                   | \$45.20<br><br>You must continue to pay your Medicare Part B premium.                                               |
| <b>Part B Premium Reduction</b>                                                                                                             | This plan offers a \$25 give back every month in your Social Security check.                                        | <u>Not</u> Available                                                                                                | <u>Not</u> Available                                                                                                |
| <b>Deductible</b>                                                                                                                           | \$260 in-network deductible for select Part B services                                                              | No deductible for medical. See prescription drugs section for Part D deductible.                                    | No deductible for medical. See prescription drugs section for Part D deductible.                                    |
| <b>Maximum Out-of-Pocket (MOOP) Responsibility</b><br>(does not include prescription drugs)                                                 | \$9,250 annually<br>This is the most you will pay in copays and coinsurance for Part A and B services for the year. | \$9,250 annually<br>This is the most you will pay in copays and coinsurance for Part A and B services for the year. | \$9,250 annually<br>This is the most you will pay in copays and coinsurance for Part A and B services for the year. |

## Benefits

|                                                                         | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                         | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                        | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                           |
|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Hospital Coverage</b>                                      | <p>For each admission, you pay:</p> <ul style="list-style-type: none"> <li>\$1,745 copay per stay for days 1 through 90</li> </ul> <p>*</p> | <p>For each admission, you pay:</p> <ul style="list-style-type: none"> <li>\$375 copay per day for days 1 through 7</li> <li>\$0 copay per day for days 8 through 90</li> </ul> <p>*</p> | <p>For each admission, you pay:</p> <ul style="list-style-type: none"> <li>\$375 copay per day for days 1 through 7</li> <li>\$0 copay per day for days 8 through 90</li> <li>\$0 copay per day for days 91 through 120</li> </ul> <p>*</p> |
| <b>Outpatient Hospital Coverage</b><br><br>Outpatient Hospital Services | <p>\$0 copay for skin biopsies.<br/>30% coinsurance for all other outpatient services.</p> <p>*</p>                                         | <p>\$0 copay for skin biopsies.<br/>30% coinsurance for all other outpatient services.</p> <p>*</p>                                                                                      | <p>\$0 copay for skin biopsies.<br/>30% coinsurance for all other outpatient services.</p> <p>*</p>                                                                                                                                         |

## Benefits

|                                                      | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                                                | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                                                                  | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                  |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient Hospital<br>Observation Services          | \$115 copay for outpatient observation services when you enter observation status through an emergency room. 30% coinsurance for outpatient observation services when you enter observation status through an outpatient facility. | \$115 copay for outpatient observation services when you enter observation status through an emergency room. 30% coinsurance for outpatient observation services when you enter observation status through an outpatient facility. | \$115 copay for outpatient observation services when you enter observation status through an emergency room. 30% coinsurance for outpatient observation services when you enter observation status through an outpatient facility. |
| <b>Ambulatory Surgical Center<br/>(ASC) Services</b> | \$250 copay for each Medicare-covered visit to an ambulatory surgical center.<br>*                                                                                                                                                 | \$250 copay for each Medicare-covered visit to an ambulatory surgical center.<br>*                                                                                                                                                 | \$250 copay for each Medicare-covered visit to an ambulatory surgical center.<br>*                                                                                                                                                 |
| <b>Doctor Visits</b>                                 |                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                    |
| Primary Care Providers                               | \$0 copay                                                                                                                                                                                                                          | \$0 copay                                                                                                                                                                                                                          | \$0 copay                                                                                                                                                                                                                          |
| Specialists                                          | \$50 copay<br>*                                                                                                                                                                                                                    | \$55 copay<br>*                                                                                                                                                                                                                    | \$25 copay<br>*                                                                                                                                                                                                                    |

Benefits

|                                                                                                                                                                                                                                                                                                                                                                                                    | Wellcare Giveback<br>(HMO-POS)<br>H0913, Plan 021,<br>000                         | Wellcare Simple<br>(HMO-POS)<br>H0913, Plan 022,<br>000                           | Wellcare Assist<br>(HMO-POS)<br>H0913, Plan 015,<br>000                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>Preventive Care</b> (e.g., Annual Wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular screenings, Cervical and vaginal cancer screening, Colorectal cancer screenings, Diabetes screenings, Hepatitis B Virus Screening, Prostate cancer screenings (PSA), Vaccines (including Flu/influenza shots, Hepatitis B shots, Pneumococcal shots, COVID shots)) | \$0 copay                                                                         | \$0 copay                                                                         | \$0 copay                                                                         |
| <b>Emergency Care</b>                                                                                                                                                                                                                                                                                                                                                                              | \$115 copay<br>Copay is waived if you are admitted to a hospital within 24 hours. | \$115 copay<br>Copay is waived if you are admitted to a hospital within 24 hours. | \$115 copay<br>Copay is waived if you are admitted to a hospital within 24 hours. |

## Benefits

|                                 | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                                                                                                                                                       | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                                                                                                                                                                         | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                                                                                                                         |
|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Worldwide Emergency Coverage    | <p>\$115 copay</p> <p>Worldwide emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is <u>not</u> waived if admitted to the hospital for worldwide emergency services.</p> | <p>\$115 copay</p> <p>Worldwide emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is <u>not</u> waived if admitted to the hospital for worldwide emergency services.</p> | <p>\$115 copay</p> <p>Worldwide emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is <u>not</u> waived if admitted to the hospital for worldwide emergency services.</p> |
| <b>Urgently Needed Services</b> | <p>\$40 copay<br/>Copay is waived if you are admitted to a hospital within 24 hours.</p>                                                                                                                                                                                                                                                  | <p>\$25 copay<br/>Copay is waived if you are admitted to a hospital within 24 hours.</p>                                                                                                                                                                                                                                                  | <p>\$25 copay<br/>Copay is waived if you are admitted to a hospital within 24 hours.</p>                                                                                                                                                                                                                                                  |

## Benefits

|                                                             | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                                                      | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                                                                        | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                        |
|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Worldwide Urgent Care Coverage                              | <p>\$115 copay</p> <p>Worldwide emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is <u>not</u> waived if admitted to the hospital for worldwide urgently needed services.</p> | <p>\$115 copay</p> <p>Worldwide emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is <u>not</u> waived if admitted to the hospital for worldwide urgently needed services.</p> | <p>\$115 copay</p> <p>Worldwide emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is <u>not</u> waived if admitted to the hospital for worldwide urgently needed services.</p> |
| <b>Diagnostic Services/Labs/Imaging</b><br><br>Lab Services | <p>\$0 for labs related to A1C and kidney health evaluation. \$50 copay for genetic testing. \$20 copay for all other labs.<br/>*</p>                                                                                                    | <p>\$50 copay for genetic testing. \$0 copay for all other labs.<br/>*</p>                                                                                                                                                               | <p>\$50 copay for genetic testing. \$0 copay for all other labs.<br/>*</p>                                                                                                                                                               |

## Benefits

|                                                    | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                           | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                            | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                            |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic Tests and Procedures                    | \$0 copay for Medicare-covered diagnostic colonoscopy, spirometry testing and specified testing related services.<br>\$100 copay for all other services.<br>* | \$0 copay for Medicare-covered diagnostic colonoscopy, spirometry testing and specified testing related services.<br>\$75 copay for all other services.<br>* | \$0 copay for Medicare-covered diagnostic colonoscopy, spirometry testing and specified testing related services.<br>\$50 copay for all other services.<br>* |
| Outpatient X-rays                                  | \$50 copay<br>*                                                                                                                                               | \$50 copay<br>*                                                                                                                                              | \$50 copay<br>*                                                                                                                                              |
| Diagnostic Radiology Services (e.g. MRI, CAT Scan) | 0% coinsurance for a diagnostic mammogram<br>30% coinsurance for all other diagnostic radiology services<br>*                                                 | \$0 copay for a diagnostic mammogram.<br>30% coinsurance for all other diagnostic radiology services.<br>*                                                   | 0% coinsurance for a diagnostic mammogram.<br>30% coinsurance for all other diagnostic radiology services.<br>*                                              |
| Therapeutic Radiology                              | 20% coinsurance<br>*                                                                                                                                          | 20% coinsurance<br>*                                                                                                                                         | 20% coinsurance<br>*                                                                                                                                         |
| <b>Hearing Services</b>                            |                                                                                                                                                               |                                                                                                                                                              |                                                                                                                                                              |
| Hearing Exam<br>Medicare-covered                   | \$50 copay<br>*                                                                                                                                               | \$55 copay<br>*                                                                                                                                              | \$25 copay<br>*                                                                                                                                              |
| Routine Hearing Exam                               | \$0 copay<br>*<br><br>1 exam(s) every year                                                                                                                    | <u>Not</u> covered                                                                                                                                           | \$0 copay<br>*<br><br>1 exam(s) every year                                                                                                                   |

## Benefits

|                                            | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                       | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                         | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                         |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hearing Aid Fitting/Evaluation(s)          | \$0 copay<br>*<br>1 fitting(s) /<br>evaluation(s) every<br>year<br>Hearing aids are<br><u>not</u> covered                                                                                 | <u>Not</u> covered                                                                                                                                                                        | \$0 copay<br>*<br>1 fitting(s) /<br>evaluation(s) every<br>year<br>Hearing aids are<br><u>not</u> covered                                                                                 |
| Additional Hearing Information             | <b>What you should know</b><br>Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment. | <b>What you should know</b><br>Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment. | <b>What you should know</b><br>Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment. |
| <b>Dental Services</b>                     |                                                                                                                                                                                           |                                                                                                                                                                                           |                                                                                                                                                                                           |
| Medicare-covered                           | \$50 copay for each Medicare-covered service.<br>*                                                                                                                                        | \$55 copay for each Medicare-covered service.<br>*                                                                                                                                        | \$25 copay for each Medicare-covered service.<br>*                                                                                                                                        |
| Routine Diagnostic and Preventive Services | <b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>*                                                                                                  | <b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>*                                                                                                  | <b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>*                                                                                                  |

## Benefits

|                                  | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                                                                    | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                                                                                      | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                                      |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Fluoride Treatment               | Cleanings 2 every year<br><br>Dental x-rays 1 set(s) every date of service to 3 plan years depending on type of service<br><br>Oral exams 2 every year<br><br><b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>* | Cleanings 2 every year<br><br>Dental x-rays 1 set(s) every date of service to 3 plan years depending on type of service<br><br>Oral exams 2 every year<br><br><b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>* | Cleanings 2 every year<br><br>Dental x-rays 1 set(s) every date of service to 3 plan years depending on type of service<br><br>Oral exams 2 every year<br><br><b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>* |
| Other Diagnostic Dental Services | 1 every year<br><br><b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>*<br><br>1 every date of service to 3 plan years depending on type of service                                                               | 1 every year<br><br><b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>*<br><br>1 every date of service to 3 plan years depending on type of service                                                               | 1 every year<br><br><b>In-Network</b><br>\$0 copay<br>*<br><br><b>Out-of-Network</b><br>25% coinsurance<br>*<br><br>1 every date of service to 3 plan years depending on type of service                                                               |

## Benefits

|                                     | Wellcare Giveback<br>(HMO-POS)<br>H0913, Plan 021,<br>000                     | Wellcare Simple<br>(HMO-POS)<br>H0913, Plan 022,<br>000                       | Wellcare Assist<br>(HMO-POS)<br>H0913, Plan 015,<br>000                       |
|-------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Other Preventive Dental<br>Services | <b>In-Network</b><br>\$0 copay<br>*                                           | <b>In-Network</b><br>\$0 copay<br>*                                           | <b>In-Network</b><br>\$0 copay<br>*                                           |
|                                     | <b>Out-of-Network</b><br>25% coinsurance<br>*                                 | <b>Out-of-Network</b><br>25% coinsurance<br>*                                 | <b>Out-of-Network</b><br>25% coinsurance<br>*                                 |
|                                     | 1 every date of<br>service to 3 plan<br>years depending<br>on type of service | 1 every date of<br>service to 3 plan<br>years depending<br>on type of service | 1 every date of<br>service to 3 plan<br>years depending<br>on type of service |
| Routine Comprehensive<br>Services   |                                                                               |                                                                               |                                                                               |
| Restorative Services                | <b>In-Network</b><br><u>Not</u> covered                                       | <b>In-Network</b><br><u>Not</u> covered                                       | <b>In-Network</b><br>20% coinsurance<br>*                                     |
|                                     | <b>Out-of-Network</b><br><u>Not</u> covered                                   | <b>Out-of-Network</b><br><u>Not</u> covered                                   | <b>Out-of-Network</b><br>30% coinsurance<br>*                                 |
| Endodontics/Periodontics            | <b>In-Network</b><br><u>Not</u> covered                                       | <b>In-Network</b><br><u>Not</u> covered                                       | <b>In-Network</b><br>20% coinsurance<br>*                                     |
|                                     | <b>Out-of-Network</b><br><u>Not</u> covered                                   | <b>Out-of-Network</b><br><u>Not</u> covered                                   | <b>Out-of-Network</b><br>30% coinsurance<br>*                                 |

## Benefits

|                               | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                  | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                        |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Oral/Maxillofacial Surgery    | <b>In-Network</b><br><u>Not</u> covered                                                                                                                                            | <b>In-Network</b><br><u>Not</u> covered                                                                                                                                            | <b>In-Network</b><br>20% coinsurance<br>*                                                                                                                                                                |
|                               | <b>Out-of-Network</b><br><u>Not</u> covered                                                                                                                                        | <b>Out-of-Network</b><br><u>Not</u> covered                                                                                                                                        | <b>Out-of-Network</b><br>30% coinsurance<br>*                                                                                                                                                            |
| Adjunctive General Services   | <b>In-Network</b><br>\$0 copay<br>*                                                                                                                                                | <b>In-Network</b><br>\$0 copay<br>*                                                                                                                                                | <b>In-Network</b><br>20% coinsurance<br>*                                                                                                                                                                |
|                               | <b>Out-of-Network</b><br>25% coinsurance<br>*                                                                                                                                      | <b>Out-of-Network</b><br>25% coinsurance<br>*                                                                                                                                      | <b>Out-of-Network</b><br>30% coinsurance<br>*                                                                                                                                                            |
|                               | <b>For more<br/>information,<br/>limitations and<br/>exclusions, please<br/>see your Evidence<br/>of Coverage.<br/>Additional dental<br/>limitations and<br/>exclusions apply.</b> | <b>For more<br/>information,<br/>limitations and<br/>exclusions, please<br/>see your Evidence<br/>of Coverage.<br/>Additional dental<br/>limitations and<br/>exclusions apply.</b> | <b>For more<br/>information,<br/>limitations and<br/>exclusions, please<br/>see your Evidence<br/>of Coverage.<br/>Additional dental<br/>limitations and<br/>exclusions apply.</b>                       |
| Additional Dental Information | <b>What you should<br/>know:</b><br>This plan provides<br>dental services<br>with no annual<br>maximum<br>allowance.<br><br>You may use either<br>in-network or<br>out-of-network  | <b>What you should<br/>know:</b><br>This plan provides<br>dental services<br>with no annual<br>maximum<br>allowance.<br><br>You may use either<br>in-network or                    | <b>What you should<br/>know:</b><br>This plan includes<br>coverage up to<br>\$1,000 per plan<br>year for all<br>in-network and<br>out-of-network<br>covered routine<br>comprehensive<br>dental services. |

## Benefits

|                                                        | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                                                                                                 | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                                                                                                                                  | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        | dentists for routine dental care (non-Medicare-covered services). Your out-of-pocket costs may be higher if you use out-of-network providers. Out-of-network providers are not contracted to accept plan payment as payment in full. They might charge you more than the plan pays. | out-of-network dentists for routine dental care (non-Medicare-covered services). Your out-of-pocket costs may be higher if you use out-of-network providers. Out-of-network providers are not contracted to accept plan payment as payment in full. They might charge you more than the plan pays. | You may use either in-network or out-of-network dentists for routine dental care (non-Medicare-covered services). Your out-of-pocket costs may be higher if you use out-of-network providers. Out-of-network providers are not contracted to accept plan payment as payment in full. They might charge you more than the plan pays. |
| <b>Vision Care</b><br><br>Eye Exam<br>Medicare-covered | \$0 copay for each Medicare-covered diabetic retinopathy screening or diabetic eye exam<br><br>\$50 copay for all other Medicare-covered eye exams *                                                                                                                                | \$0 copay for each Medicare-covered diabetic retinopathy screening or diabetic eye exam<br><br>\$55 copay for all other Medicare-covered eye exams *                                                                                                                                               | \$0 copay for each Medicare-covered diabetic retinopathy screening or diabetic eye exam<br><br>\$25 copay for all other Medicare-covered eye exams *                                                                                                                                                                                |

## Benefits

|                                                                                                                      | Wellcare Giveback<br>(HMO-POS)<br>H0913, Plan 021,<br>000                                                                                | Wellcare Simple<br>(HMO-POS)<br>H0913, Plan 022,<br>000 | Wellcare Assist<br>(HMO-POS)<br>H0913, Plan 015,<br>000                                                                                  |
|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| Routine Eye Exam (Refraction)                                                                                        | \$0 copay<br>*<br><br>1 exam(s) every<br>year                                                                                            | <u>Not</u> covered                                      | \$0 copay<br>*<br><br>1 exam(s) every<br>year                                                                                            |
| Glaucoma Screening                                                                                                   | \$0 copay for each<br>Medicare-covered<br>service.                                                                                       | \$0 copay for each<br>Medicare-covered<br>service.      | \$0 copay for each<br>Medicare-covered<br>service.                                                                                       |
| Eyewear<br>Medicare-covered                                                                                          | \$0 copay                                                                                                                                | \$0 copay                                               | \$0 copay                                                                                                                                |
| Routine Eyewear<br><br>Contact Lenses/ Eyeglasses<br>(frame and lenses)/<br>Eyeglass Frames<br><br>Eyewear Allowance | \$0 copay<br>*<br><br>Up to a \$100<br>combined<br>allowance towards<br>contacts and<br>glasses (lenses<br>and/or frames)<br>every year. | <u>Not</u> covered                                      | \$0 copay<br>*<br><br>Up to a \$100<br>combined<br>allowance towards<br>contacts and<br>glasses (lenses<br>and/or frames)<br>every year. |

## Benefits

|                                       | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                                                  | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                                                                    | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                    |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Mental Health Services</b>         |                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                      |
| Inpatient Visit                       | For each admission, you pay: <ul style="list-style-type: none"> <li>\$1,745 copay per stay for days 1 through 90</li> </ul> *                                                                                                        | For each admission, you pay: <ul style="list-style-type: none"> <li>\$2,075 copay per stay for days 1 through 90</li> </ul> *                                                                                                        | For each admission, you pay: <ul style="list-style-type: none"> <li>\$295 copay per day for days 1 through 7</li> <li>\$0 copay per day for days 8 through 90</li> </ul> *                                                           |
| Outpatient Individual Therapy Visit   | \$40 copay<br>*                                                                                                                                                                                                                      | \$25 copay<br>*                                                                                                                                                                                                                      | \$25 copay<br>*                                                                                                                                                                                                                      |
| Outpatient Group Therapy Visit        | \$40 copay<br>*                                                                                                                                                                                                                      | \$25 copay<br>*                                                                                                                                                                                                                      | \$25 copay<br>*                                                                                                                                                                                                                      |
| <b>Skilled Nursing Facility (SNF)</b> | For each benefit period, you pay: <ul style="list-style-type: none"> <li>\$0 copay per day for days 1 through 20</li> <li>\$218 copay per day for days 21 through 70</li> <li>\$0 copay per day for days 71 through 100</li> </ul> * | For each benefit period, you pay: <ul style="list-style-type: none"> <li>\$0 copay per day for days 1 through 20</li> <li>\$218 copay per day for days 21 through 70</li> <li>\$0 copay per day for days 71 through 100</li> </ul> * | For each benefit period, you pay: <ul style="list-style-type: none"> <li>\$0 copay per day for days 1 through 20</li> <li>\$218 copay per day for days 21 through 70</li> <li>\$0 copay per day for days 71 through 100</li> </ul> * |

## Benefits

|                                                                           | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                           | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                             | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                             |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| <b>Therapy and Rehabilitation Services</b>                                |                                                                                                                               |                                                                                                                               |                                                                                                                               |
| Physical Therapy                                                          | \$35 copay<br>*                                                                                                               | \$35 copay<br>*                                                                                                               | \$30 copay<br>*                                                                                                               |
| Outpatient Rehabilitation Services Provided by an Occupational Therapist  | \$35 copay<br>*                                                                                                               | \$35 copay<br>*                                                                                                               | \$30 copay<br>*                                                                                                               |
| Pulmonary Rehabilitation Services                                         | \$25 copay                                                                                                                    | \$25 copay                                                                                                                    | \$25 copay                                                                                                                    |
| <b>Ambulance</b>                                                          |                                                                                                                               |                                                                                                                               |                                                                                                                               |
| Ground Ambulance                                                          | \$260 copay<br>*                                                                                                              | \$305 copay<br>*                                                                                                              | \$325 copay<br>*                                                                                                              |
| Air Ambulance                                                             | \$260 copay<br>*                                                                                                              | \$305 copay<br>*                                                                                                              | \$325 copay<br>*                                                                                                              |
| <b>Transportation Services<br/>(Non-emergency medical transportation)</b> | <u>Not</u> covered                                                                                                            | <u>Not</u> covered                                                                                                            | <u>Not</u> covered                                                                                                            |
| <b>Medicare Part B Drugs</b>                                              |                                                                                                                               |                                                                                                                               |                                                                                                                               |
| Chemotherapy Drugs and Other Part B Drugs                                 | 20% coinsurance<br>*<br><br>Certain Part B rebatable drugs may be subject to a lower coinsurance than the amount shown above. | 20% coinsurance<br>*<br><br>Certain Part B rebatable drugs may be subject to a lower coinsurance than the amount shown above. | 20% coinsurance<br>*<br><br>Certain Part B rebatable drugs may be subject to a lower coinsurance than the amount shown above. |

**Benefits**

|                 | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b> | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b> | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b> |
|-----------------|---------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------|
| Insulin         | \$35 copay<br>(maximum per<br>month)<br>*                           | \$35 copay<br>(maximum per<br>month)<br>*                         | \$35 copay<br>(maximum per<br>month)<br>*                         |
| Allergy Antigen | 0% coinsurance<br>*                                                 | 0% coinsurance<br>*                                               | 0% coinsurance<br>*                                               |

| Part D Prescription Drug Coverage                                                                                                                                                | Wellcare Giveback (HMO-POS)<br>H0913, Plan 021, 000                                                                                                                                                                                                                    | Wellcare Simple (HMO-POS)<br>H0913, Plan 022, 000                                                                                                                                                                                                                      | Wellcare Assist (HMO-POS)<br>H0913, Plan 015, 000                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Stage 1: Yearly Deductible Stage</b>                                                                                                                                          |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                          |
| If a plan has a Part D drug deductible, the deductible doesn't apply to covered insulin products and most adult Part D vaccines including shingles, tetanus and travel vaccines. |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                          |
| <b>Deductible</b>                                                                                                                                                                | \$615 for Part D prescription drugs (this applies to drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier)). For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately. | \$615 for Part D prescription drugs (this applies to drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier)). For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately. | \$615 for Part D prescription drugs (this applies to drugs on Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier)). For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately. |
| <b>Stage 2: Initial Coverage Stage (after you pay your deductible, if applicable)</b>                                                                                            |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                          |
| You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,100. You then move on to the Catastrophic Coverage Stage.                                  |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                          |
| <b>What You Pay for Vaccines:</b><br>Our plan covers most Part D vaccines at no cost to you, even if you have not paid your deductible.                                          |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                          |

| Part D Prescription Drug Coverage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Wellcare Giveback (HMO-POS)<br>H0913, Plan 021, 000 | Wellcare Simple (HMO-POS)<br>H0913, Plan 022, 000 | Wellcare Assist (HMO-POS)<br>H0913, Plan 015, 000 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------|---------------------------------------------------|
| <p><b>What You Pay for Insulin:</b></p> <p><b>Wellcare Giveback (HMO-POS) Tier 3:</b> You won't pay more than the lesser of 25% of our negotiated price for the drug or \$35 for up to a 1-month supply, the lesser of 25% of our negotiated price for the drug or \$70 for up to a 2-month supply, or the lesser of 25% of our negotiated price for the drug or \$105 for up to a 3-month supply of each covered insulin product, even if you have not paid your deductible.</p> <p><b>Tier 4:</b> You won't pay more than the lesser of 25% of our negotiated price for the drug or \$35 for up to a 1-month supply, the lesser of 25% of our negotiated price for the drug or \$70 for up to a 2-month supply, or the lesser of 25% of our negotiated price for the drug or \$105 for up to a 3-month supply of each covered insulin product, even if you have not paid your deductible.</p> <p><b>Wellcare Simple (HMO-POS) Tier 3:</b> You won't pay more than the lesser of 25% of our negotiated price for the drug or \$35 for up to a 1-month supply, the lesser of 25% of our negotiated price for the drug or \$70 for up to a 2-month supply, or the lesser of 25% of our negotiated price for the drug or \$105 for up to a 3-month supply of each covered insulin product, even if you have not paid your deductible.</p> <p><b>Tier 4:</b> You won't pay more than the lesser of 25% of our negotiated price for the drug or \$35 for up to a 1-month supply, the lesser of 25% of our negotiated price for the drug or \$70 for up to a 2-month supply, or the lesser of 25% of our negotiated price for the drug or \$105 for up to a 3-month supply of each covered insulin product, even if you have not paid your deductible.</p> <p><b>Wellcare Assist (HMO-POS) Tier 3:</b> You won't pay more than the lesser of 20% of our negotiated price for the drug or \$35 for up to a 1-month supply, the lesser of 20% of our negotiated price for the drug or \$70 for up to a 2-month supply, or the lesser of 20% of our negotiated price for the drug or \$105 for up to a 3-month supply of each covered insulin product, even if you have not paid your deductible.</p> <p><b>Tier 4:</b> You won't pay more than the lesser of 25% of our negotiated price for the drug or \$35 for up to a 1-month supply, the lesser of 25% of our negotiated price for the drug or \$70 for up to a 2-month supply, or the lesser of 25% of our negotiated price for the drug or \$105 for up to a 3-month supply of each covered insulin product, even if you have not paid your deductible.</p> |                                                     |                                                   |                                                   |

| Part D Prescription Drug Coverage                                                          | Wellcare Giveback (HMO-POS)<br>H0913, Plan 021, 000 |                                         | Wellcare Simple (HMO-POS)<br>H0913, Plan 022, 000 |                                         | Wellcare Assist (HMO-POS)<br>H0913, Plan 015, 000 |                                         |
|--------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------|---------------------------------------------------|-----------------------------------------|---------------------------------------------------|-----------------------------------------|
| Stage 2: Initial Coverage Stage (after you pay your deductible, if applicable) (Continued) |                                                     |                                         |                                                   |                                         |                                                   |                                         |
| Retail cost-sharing (30-day / 100-day supply)                                              |                                                     |                                         |                                                   |                                         |                                                   |                                         |
| For more details on tier descriptions, please see the Evidence of Coverage.                |                                                     |                                         |                                                   |                                         |                                                   |                                         |
|                                                                                            | Preferred                                           | Standard                                | Preferred                                         | Standard                                | Preferred                                         | Standard                                |
| Tier 1<br>(Preferred Generic)                                                              | \$0 / \$0<br>copay                                  | \$5 / \$15<br>copay                     | \$0 / \$0<br>copay                                | \$5 / \$15<br>copay                     | \$10 / \$30<br>copay                              | \$19 / \$57<br>copay                    |
| Tier 2<br>(Generic)                                                                        | \$0 / \$0<br>copay                                  | \$10 / \$30<br>copay                    | \$0 / \$0<br>copay                                | \$10 / \$30<br>copay                    | \$19 / \$57<br>copay                              | \$20 / \$60<br>copay                    |
| Tier 3<br>(Preferred Brand)                                                                | 25% / 25%<br>co-insurance                           | 25% / 25%<br>co-insurance               | 25% / 25%<br>co-insurance                         | 25% / 25%<br>co-insurance               | 20% / 20%<br>co-insurance                         | 20% / 20%<br>co-insurance               |
| Tier 4<br>(Non-Preferred Drug)                                                             | 36% / 36%<br>co-insurance                           | 36% / 36%<br>co-insurance               | 37% / 37%<br>co-insurance                         | 39% / 39%<br>co-insurance               | \$100 / \$300<br>copay                            | \$100 / \$300<br>copay                  |
| Tier 5<br>(Specialty Tier)<br>Limited to 30 day supply                                     | 25% co-insurance/<br><u>Not</u> Available           | 25% co-insurance / <u>Not</u> Available | 25% co-insurance / <u>Not</u> Available           | 25% co-insurance / <u>Not</u> Available | 25% co-insurance / <u>Not</u> Available           | 25% co-insurance / <u>Not</u> Available |
| Tier 6<br>(Select Care Drugs)                                                              | \$0 / \$0<br>copay                                  | \$0 / \$0<br>copay                      | \$0 / \$0<br>copay                                | \$0 / \$0<br>copay                      | \$0/\$0<br>copay                                  | \$0 / \$0<br>copay                      |

| Part D Prescription Drug Coverage                                                                                                        | Wellcare Giveback (HMO-POS)<br>H0913, Plan 021, 000                                                                                                            | Wellcare Simple (HMO-POS)<br>H0913, Plan 022, 000 | Wellcare Assist (HMO-POS)<br>H0913, Plan 015, 000                                                                                                              |                  |                                                                                                                                                                |                  |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Stage 2: Initial Coverage Stage (after you pay your deductible, if applicable) (Continued)                                               |                                                                                                                                                                |                                                   |                                                                                                                                                                |                  |                                                                                                                                                                |                  |
| Mail-order cost-sharing (100-day supply)                                                                                                 |                                                                                                                                                                |                                                   |                                                                                                                                                                |                  |                                                                                                                                                                |                  |
|                                                                                                                                          | Preferred                                                                                                                                                      | Standard                                          | Preferred                                                                                                                                                      | Standard         | Preferred                                                                                                                                                      | Standard         |
| Tier 1<br>(Preferred Generic)                                                                                                            | \$0 copay                                                                                                                                                      | \$15 copay                                        | \$0 copay                                                                                                                                                      | \$15 copay       | \$0 copay                                                                                                                                                      | \$57 copay       |
| Tier 2<br>(Generic)                                                                                                                      | \$0 copay                                                                                                                                                      | \$30 copay                                        | \$0 copay                                                                                                                                                      | \$30 copay       | \$0 copay                                                                                                                                                      | \$60 copay       |
| Tier 3<br>(Preferred Brand)                                                                                                              | 25% co-insurance                                                                                                                                               | 25% co-insurance                                  | 25% co-insurance                                                                                                                                               | 25% co-insurance | 20% co-insurance                                                                                                                                               | 20% co-insurance |
| Tier 4<br>(Non-Preferred Drug)                                                                                                           | 36% co-insurance                                                                                                                                               | 36% co-insurance                                  | 37% co-insurance                                                                                                                                               | 39% co-insurance | \$200 copay                                                                                                                                                    | \$300 copay      |
| Tier 5<br>(Specialty Tier)<br>Limited to 30 day supply                                                                                   | Not Available                                                                                                                                                  | Not Available                                     | Not Available                                                                                                                                                  | Not Available    | Not Available                                                                                                                                                  | Not Available    |
| Tier 6<br>(Select Care Drugs)                                                                                                            | \$0 copay                                                                                                                                                      | \$0 copay                                         | \$0 copay                                                                                                                                                      | \$0 copay        | \$0 copay                                                                                                                                                      | \$0 copay        |
| Stage 3: Catastrophic Coverage Stage                                                                                                     |                                                                                                                                                                |                                                   |                                                                                                                                                                |                  |                                                                                                                                                                |                  |
| During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing for the rest of the calendar year. |                                                                                                                                                                |                                                   |                                                                                                                                                                |                  |                                                                                                                                                                |                  |
|                                                                                                                                          | You enter this stage after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100. |                                                   | You enter this stage after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100. |                  | You enter this stage after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100. |                  |

Generic drugs may be covered on tiers other than Tier 1 and Tier 2. Please check the plan's Formulary to validate the specific tier on which your drugs are covered.

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or the day supply received. Mail order prescriptions are dispensed at a quantity of 35 days or more.

**Excluded Drugs:**

Wellcare Giveback (HMO-POS) and Wellcare Simple (HMO-POS) include enhanced drug coverage of certain excluded drugs, such as Tier 1 folic acid, vitamin B12, vitamin D2, generic-only sildenafil and vardenafil. Generic sildenafil and vardenafil have a quantity limit of six pills every 30 days.

Because these drugs are excluded from Part D coverage under Medicare, they are not covered by Extra Help. Also, the amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage.

Please see your Formulary and Evidence of Coverage for details regarding this drug coverage.

**Medicare Prescription Payment Plan**

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).

To learn more about this payment option, please contact us at 1-833-750-9969. (TTY only, call 1-800-716-3231.) We are available for phone calls 24 hours a day, 7 days a week or visit [go.wellcare.com/MPPP](https://go.wellcare.com/MPPP).

## Additional Benefits

|                                                                                                                                             | Wellcare Giveback<br>(HMO-POS)<br>H0913, Plan 021,<br>000                                                                                                                                                                                   | Wellcare Simple<br>(HMO-POS)<br>H0913, Plan 022,<br>000                                                                                                                                                                                     | Wellcare Assist<br>(HMO-POS)<br>H0913, Plan 015,<br>000                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Note:</b> Services with an asterisk (*) may require prior authorization.<br>Services with a square (■) means a referral may be required. |                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                             |
| <b>Chiropractic Services</b><br><br>Medicare-covered                                                                                        | \$15 copay<br>*                                                                                                                                                                                                                             | \$15 copay<br>*                                                                                                                                                                                                                             | \$15 copay<br>*                                                                                                                                                                                                                             |
| <b>Acupuncture</b><br><br>Medicare-covered                                                                                                  | \$0 copay for Medicare-covered Acupuncture received in a PCP office.<br>\$15 copay for Medicare-covered Acupuncture received in a Chiropractor office.<br>\$50 copay for Medicare-covered Acupuncture received in a Specialist office.<br>* | \$0 copay for Medicare-covered Acupuncture received in a PCP office.<br>\$15 copay for Medicare-covered Acupuncture received in a Chiropractor office.<br>\$55 copay for Medicare-covered Acupuncture received in a Specialist office.<br>* | \$0 copay for Medicare-covered Acupuncture received in a PCP office.<br>\$15 copay for Medicare-covered Acupuncture received in a Chiropractor office.<br>\$25 copay for Medicare-covered Acupuncture received in a Specialist office.<br>* |
| Routine Acupuncture Services                                                                                                                | <u>Not</u> covered                                                                                                                                                                                                                          | \$0 copay<br>*<br><br>Limited to 24 visit(s) every year                                                                                                                                                                                     | <u>Not</u> covered                                                                                                                                                                                                                          |

## Additional Benefits

|                                                          | Wellcare Giveback<br>(HMO-POS)<br>H0913, Plan 021,<br>000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Wellcare Simple<br>(HMO-POS)<br>H0913, Plan 022,<br>000 | Wellcare Assist<br>(HMO-POS)<br>H0913, Plan 015,<br>000 |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|
| <b>Podiatry Services (Foot Care)</b><br>Medicare-covered | \$50 copay<br>*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$55 copay<br>*                                         | \$25 copay<br>*                                         |
| <b>Virtual Visits</b>                                    | <p>\$0 copay for virtual visit services performed through your plan's virtual visit provider(s).</p> <p>Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more.</p> <p>A virtual visit (also known as telehealth or telemedicine) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.</p> <p>For more information, please see your Evidence of Coverage.</p> <p><b>What you should know:</b></p> <p>The \$0 copay above only applies when services are received from your plan's virtual visit provider(s). If you receive telemedicine services from a network provider and not your plan's virtual visit provider(s), you will pay the cost shares listed for those providers, as outlined within the Evidence of Coverage (e.g., if you receive telehealth services from your PCP, you will pay the PCP cost share).</p> |                                                         |                                                         |
| <b>Social Support Platform</b>                           | <p>Our plan provides an online and app-based support platform for your overall well-being. The platform offers personalized therapeutic self-guided activities and programs to help manage stress, anxiety, and support your emotional and mental health.</p> <p>Engage in interactive activities, meditations and games tailored to your needs. The platform also features the ability to join social communities.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                         |                                                         |

## Additional Benefits

|                                                                         | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                 | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                             | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                             |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
|                                                                         | <p>Available online 24/7 - you can use it whenever you choose.</p> <p>For more information on how to access the social support platform, please see your Evidence of Coverage.</p> <p>\$0 copay</p> |                                                                                                               |                                                                                                               |
| <b>Home Health Agency Care</b>                                          | \$0 copay<br>*                                                                                                                                                                                      | \$0 copay<br>*                                                                                                | \$0 copay<br>*                                                                                                |
| <b>Medical Equipment/Supplies</b><br>Durable Medical Equipment<br>(DME) | 20% coinsurance<br>*                                                                                                                                                                                | 20% coinsurance<br>*                                                                                          | 20% coinsurance<br>*                                                                                          |
| Prosthetics                                                             | 20% coinsurance<br>*                                                                                                                                                                                | 20% coinsurance<br>*                                                                                          | 20% coinsurance<br>*                                                                                          |
| Diabetic Supplies                                                       | \$0 copay<br>*<br><br>For more information, limitations and exclusions, please see your Evidence of Coverage.                                                                                       | \$0 copay<br>*<br><br>For more information, limitations and exclusions, please see your Evidence of Coverage. | \$0 copay<br>*<br><br>For more information, limitations and exclusions, please see your Evidence of Coverage. |
| Diabetic Therapeutic Shoes Or Inserts                                   | 20% coinsurance<br>*                                                                                                                                                                                | 20% coinsurance<br>*                                                                                          | 20% coinsurance<br>*                                                                                          |
| <b>Opioid Treatment Program Services</b>                                | \$50 copay<br>*                                                                                                                                                                                     | \$55 copay<br>*                                                                                               | \$25 copay<br>*                                                                                               |

## Additional Benefits

|                                                              | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Health and Wellness Education Programs</b><br><br>Fitness | <p>For a detailed list of wellness education program benefits offered, please refer to the Evidence of Coverage.</p> <p>\$0 copay</p> <p><b>What you should know:</b></p> <p>To help support an active and healthy lifestyle, your plan provides a fitness program that offers access to fitness locations nationwide. You may access one or more gyms within the fitness network.</p> <p>Members have access to in-person fitness centers, available on-demand exercise programs, and a variety of Home Fitness Kits (including a</p> | <p>For a detailed list of wellness education program benefits offered, please refer to the Evidence of Coverage.</p> <p>\$0 copay</p> <p><b>What you should know:</b></p> <p>To help support an active and healthy lifestyle, your plan provides a fitness program that offers access to fitness locations nationwide. You may access one or more gyms within the fitness network.</p> <p>Members have access to in-person fitness centers, available on-demand exercise programs, and a variety of Home Fitness Kits (including a</p> | <p>For a detailed list of wellness education program benefits offered, please refer to the Evidence of Coverage.</p> <p>\$0 copay</p> <p><b>What you should know:</b></p> <p>To help support an active and healthy lifestyle, your plan provides a fitness program that offers access to fitness locations nationwide. You may access one or more gyms within the fitness network.</p> <p>Members have access to in-person fitness centers, available on-demand exercise programs, and a variety of Home Fitness Kits (including a</p> |

## Additional Benefits

|                                     | <b>Wellcare Giveback<br/>(HMO-POS)<br/>H0913, Plan 021,<br/>000</b>                                                                                      | <b>Wellcare Simple<br/>(HMO-POS)<br/>H0913, Plan 022,<br/>000</b>                                                                                        | <b>Wellcare Assist<br/>(HMO-POS)<br/>H0913, Plan 015,<br/>000</b>                                                                                                                                                                                    |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                     | wearable fitness tracker).                                                                                                                               | wearable fitness tracker).                                                                                                                               | wearable fitness tracker).                                                                                                                                                                                                                           |
| 24-Hour Nurse Advice Line           | \$0 copay                                                                                                                                                | \$0 copay                                                                                                                                                | \$0 copay                                                                                                                                                                                                                                            |
| <b>Annual Routine Physical Exam</b> | \$0 copay<br><br><b>What you should know:</b><br>The exam includes a detailed medical/family history and recommendations for preventive screenings/care. | \$0 copay<br><br><b>What you should know:</b><br>The exam includes a detailed medical/family history and recommendations for preventive screenings/care. | \$0 copay<br><br><b>What you should know:</b><br>The exam includes a detailed medical/family history and recommendations for preventive screenings/care.                                                                                             |
| <b>Wellcare Spendables®</b>         | <u>Not</u> covered                                                                                                                                       | <u>Not</u> covered                                                                                                                                       | You will receive <b>\$40 monthly</b> preloaded on your Wellcare Spendables® card. Your monthly allowance <b>rolls over to the following month if unused and expires at the end of the plan year.</b><br><br>Your card allowance can be used towards: |

Additional Benefits

|  | Wellcare Giveback<br>(HMO-POS)<br>H0913, Plan 021,<br>000 | Wellcare Simple<br>(HMO-POS)<br>H0913, Plan 022,<br>000 | Wellcare Assist<br>(HMO-POS)<br>H0913, Plan 015,<br>000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--|-----------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |                                                           |                                                         | <p><b>Over-the-Counter items (OTC)</b> - Your card can be used at participating retail locations, through the mobile app, or online through your member portal to place an order for home delivery. Examples of covered items include brand name and generic over-the-counter items, vitamins, pain relievers, cold and allergy items and diabetic items.</p> <p><b>Dental, Vision, and Hearing</b> - You may use your card to help reduce your out-of-pocket expenses for eligible dental, vision, and hearing services.</p> <p>For more information, limitations, and exclusions, please see your Evidence of Coverage.</p> |

Additional Benefits

|                     | Wellcare Giveback<br>(HMO-POS)<br>H0913, Plan 021,<br>000                                                                                                                                                                                                                       | Wellcare Simple<br>(HMO-POS)<br>H0913, Plan 022,<br>000                                                                                                                                                                                                                         | Wellcare Assist<br>(HMO-POS)<br>H0913, Plan 015,<br>000                                                                                                                                                                        |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| My Wellcare Rewards | <p>With <b>My Wellcare Rewards</b>, you can earn up to \$100 by completing eligible health activities and portal activities through your member portal.</p> <p>Your earned rewards will be delivered to you in the form of a Debit card. Debit card restrictions may apply.</p> | <p>With <b>My Wellcare Rewards</b>, you can earn up to \$100 by completing eligible health activities and portal activities through your member portal.</p> <p>Your earned rewards will be delivered to you in the form of a Debit card. Debit card restrictions may apply.</p> | <p>With <b>My Wellcare Rewards</b>, you can earn up to \$100 by completing eligible health activities and portal activities through your member portal.</p> <p>Rewards will be loaded onto your Wellcare Spendables® card.</p> |

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-374-4056 (TTY: 711).

Español ATENCIÓN: Contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. También se encuentran disponibles de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-877-374-4056 (TTY: 711).

简体中文 注意：我们为您提供免费的语言协助服务，同时也可免费提供适当的辅助设施与服务，以便提供无障碍格式的信息。请致电 1-877-374-4056（TTY：711）。

繁體中文 注意：我們為您提供免費的語言協助服務，還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請致電 1-877-374-4056 (TTY：711)。

Português ATENÇÃO: estão disponíveis serviços de assistência gratuitos no seu idioma. Também estão disponíveis apoios auxiliares e serviços adequados que oferecem informações em formatos acessíveis e sem custos. Ligue para 1-877-374-4056 (TTY: 711).

हिंदी ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं. एक्सेस करने योग्य फॉर्मेट में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं. 1-877-374-4056 (TTY: 711) पर कॉल करें.

ગુજરાતી ધ્યાન આપવાની જરૂર છે: તમારા માટે ભાષા સંબંધી સહાયતાની મફત સેવાઓ ઉપલબ્ધ છે. એક્સેસ કરી શકાય તેવા ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-877-374-4056 (TTY: 711) પર કોલ કરો.

العربية انتباه: تتوفر لك خدمات مساعدة لغوية مجانية. تتوفر كذلك مجاناً مساعدات وخدمات إضافية ملائمة لتزويد المعلومات بتنسيقات قابلة للوصول إليها. اتصل على الرقم 1-877-374-4056 (TTY: 711).

Tagalog ATENSYON: May mga libreng serbisyo ng tulong sa wika na available para sa inyo. Available din nang libre ang mga naaangkop na karagdagang tulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format. Tumawag sa 1-877-374-4056 (TTY: 711).

한국어 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 정보 제공을 위해 적합한 보조 도구 및 서비스 또한 액세스 가능한 형식으로 무료 이용이 가능합니다. 1-877-374-4056 (TTY: 711)번으로 전화해 주십시오.

Polski UWAGA: usługi wsparcia językowego są dostępne nieodpłatnie. Bezpłatnie oferowane są również dodatkowe pomoce i usługi pozwalające na przekazanie informacji w formacie przystępnym dla odbiorcy. Zadzwoń pod numer 1-877-374-4056 (TTY: 711).

Kreyòl Ayisyen ATANSYON: Sèvis èd gratis pou lang disponib pou ou. Aparèy oksilyè ki bay asistans ak sèvis ki apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nan 1-877-374-4056 (TTY: 711).

Italiano ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili supporti e servizi ausiliari gratuiti adatti a fornire le informazioni in formati accessibili. Chiamare il numero 1-877-374-4056 (TTY: 711).

Русский ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Вы также можете бесплатно получить соответствующие вспомогательные средства и услуги, направленные на предоставление информации в доступных форматах. Позвоните по номеру 1-877-374-4056 (TTY: 711).

Yorùbá ÀKÍYÈSÍ: Àwọn iṣẹ̀ ìrànṣíwọ̀ tí èdè wà nílẹ̀ fún ọ̀ lófẹ́ẹ̀. Àwọn iṣẹ̀ àti àwọn ìrànṣíwọ̀ arannílọ̀wọ̀ tóyẹ̀ láti pèsè iwífúnni ní àwọn ọ̀nà kíkọ̀sílẹ̀ tóṣeé ráàyè sí tún wà nílẹ̀ bákan náà lófẹ́ẹ̀ láisan owó rára. Pe 1-877-374-4056 (TTY: 711).

Twi HYE NO NSO: Kasa ho mmoa dwumadie ahodoɔ wo ho ma wo a wontua hwee. Nneɛma a ebeboa wo ama wate nsem ne dwumadie ahodoɔ a ede nsem beɛma wo wo akwan bebree so nso wo ho a wontua hwee. Frɛ 1-877-374-4056 (TTY: 711).

Igbo NLERUANYA: A na-enye gi ọrụ enyemaka asụsụ n'efu. Enyemaka na ọrụ ndị kwesiri ekwesị iji nye ozi n'ụdị ndị dị mfe inweta dikrawa n'akwụghị ụgwọ. Kpọọ 1-877-374-4056 (TTY: 711).

తెలుగు గమనిక: మీకు ఉచిత భాష సంబంధ సహాయక సేవలు అందుబాటులో ఉన్నాయి. యాక్సెస్ చేయదగిన ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక టూల్స్, సేవలు కూడా ఉచితంగా అందుబాటులో ఉన్నాయి. 1-877-374-4056 (TTY: 711) నంబర్‌కి కాల్ చేయండి.

اردو توجہ: زبان معاونت کی خدمات آپ کے لیے مفت دستیاب ہیں۔ معلومات کو قابل رسائی شکل میں فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-877-374-4056 (TTY: 711) پر کال کریں۔

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service representative at 1-844-480-0680 (TTY: 711). Hours are Sunday-Saturday, 8 am to 8 pm.

### Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [go.wellcare.com/Medicare](https://go.wellcare.com/Medicare) or call 1-844-480-0680 (TTY: 711) to view a copy of the EOC. Hours are Sunday-Saturday, 8 am to 8 pm.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use. If you have a Marketplace plan, you will need to contact the Marketplace to cancel the plan. If you do not cancel your Marketplace plan, you may be paying for coverage you cannot use and there may be penalties on your next year's tax return.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers) for certain services. However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

## Contact Us

**For more information, please contact us:**



### **By phone**

Toll-free at 1-844-480-0680 (TTY: 711). Your call may be answered by a licensed agent.



### **Hours of Operation**

Sunday-Saturday, 8 am to 8 pm



### **Online**

[go.wellcare.com/Medicare](https://go.wellcare.com/Medicare)