

2021

Summary of Benefits

North Carolina

WellCare Absolute (PPO)

H7175 | Plan 004

WellCare Premier (PPO)

H7175 | Plan 001

WellCare Summit (PPO)

H7175 | Plan 003

WellCare Patriot (PPO)

H7175 | Plan 005



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 Absolute (PPO), WellCare Premier (PPO), WellCare Summit (PPO), WellCare Patriot (PPO) from January 1, 2021 to December 31, 2021.

This information does not list every service, limitation or exclusion. A complete list of services is in the plan's Evidence of Coverage. You can find the Evidence of Coverage on our website. Or you may call us to ask for a copy at the phone number listed on the back cover.

Who can join?

To join one of our plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Our plans and service area:

H7175004000 WellCare Absolute (PPO) Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

H7175001000 WellCare Premier (PPO) Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

H7175003000 WellCare Summit (PPO) Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

H7175005000 WellCare Patriot (PPO) Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

Like all Medicare health plans, our plans also cover everything that Original Medicare covers with additional benefits to support your well-being.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. Available 24 hours, 7 days a week, including some federal holidays.

Preferred Provider Organization (PPOs) Medicare Advantage Prescription Drug (MAPD) offer coverage through a network of providers, but you are allowed to access out-of-network care for covered services, usually for a higher cost. You do not need to choose a primary care doctor with a PPO, and usually you do not need a referral to see a specialist. Some plans also include giveback of some or all of the Part B premium.

Which doctors, hospitals and pharmacies can I use?

WellCare has a network of doctors, hospitals, pharmacies and other providers. You can save money by using our preferred mail-order pharmacy and by using providers in the plan's network. With some plans if you use providers that are not in our network, your share of the costs for covered services may be higher. You can see our plan's provider and pharmacy directory at our website: www.wellcare.com/medicare. Or, call and we'll send you a copy.

How will I determine my drug costs?

If your plan offers a drug benefit, you will generally have to use one of our network pharmacies to fill your

prescriptions covered by Part D. You will need to use our plan's formulary (list of covered drugs) to locate what tier your drug is on to determine how much it will cost you. Each medication will be grouped into one of the five tiers. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the drug benefit stages that occur, if applicable: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage.

This document is available in other formats such as braille, large print or audio. This document is available in languages other than English. For additional information, call us at 1-877-374-4056, (TTY/TDD 711).

For more information, please call us at 1-833-444-9088 (TTY/TDD users should call 711) Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m., or visit us at www.wellcare.com/medicare.

Summary of Benefits

January 1, 2021 - December 31, 2021

NOTE:

- Services with PA may require prior authorization
- Services with R may require a referral from your doctor

PPO plans do not require a prior authorization or referral for out-of-network services.

Plan Name	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Service Area	Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey	Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

Monthly Premium, Deductible and Limits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Monthly Plan Premium	\$0.00 What you should know You must continue to pay your Medicare Part B premium.	\$0.00 What you should know You must continue to pay your Medicare Part B premium.
Part B Premium Buy-Down	\$75.00	This plan does not offer a Part B Premium Reduction
Deductible	\$200 annually What you should know The deductible is the amount you must pay out-of-pocket for medical services before our plan begins to pay its share. See the Prescription Drug Benefits section of this document for Part D Prescription Drug Deductible information.	No Deductible What you should know See the Prescription Drug Benefits section of this document for Part D Prescription Drug Deductible information.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey	Alexander, Ashe, Avery, Bladen, Buncombe, Caswell, Catawba, Cumberland, Durham, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, Madison, McDowell, Mitchell, Orange, Person, Polk, Swain, Transylvania, Warren, Yancey

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
\$22.20 What you should know You must continue to pay your Medicare Part B premium.	\$0.00 What you should know You must continue to pay your Medicare Part B premium.
This plan does not offer a Part B Premium Reduction	This plan does not offer a Part B Premium Reduction
No Deductible What you should know See the Prescription Drug Benefits section of this document for Part D Prescription Drug Deductible information.	No Deductible

Monthly Premium, Deductible and Limits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Maximum Out-of-Pocket Responsibility(MOOP) (does not include prescription drugs)	In-Network \$7,550 annually	In-Network \$5,500 annually
	Combined and/or Out-of-Network \$10,000 annually	Combined and/or Out-of-Network \$10,000 annually
	What you should know Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. For more information on out-of-pocket costs for this plan, refer to the Evidence of Coverage.	What you should know Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. For more information on out-of-pocket costs for this plan, refer to the Evidence of Coverage.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$6,000 annually	In-Network \$5,500 annually
Combined and/or Out-of-Network \$10,000 annually	Combined and/or Out-of-Network \$10,000 annually
What you should know Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. For more information on out-of-pocket costs for this plan, refer to the Evidence of Coverage.	What you should know Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. For more information on out-of-pocket costs for this plan, refer to the Evidence of Coverage.

Medical and Hospital Benefits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Inpatient Hospital Coverage ^{PA}	In-Network \$325 co-pay per day for days 1-6 and a \$0 co-pay per day for days 7-90	In-Network \$325 co-pay per day for days 1-5 and a \$0 co-pay per day for days 6-90
	Out-of-Network 20% of the total cost for days 1-90	Out-of-Network 35% of the total cost for days 1-90
	What you should know Our plan covers a specified number of days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information.	What you should know Our plan covers a specified number of days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$350 co-pay per day for days 1-5 and a \$0 co-pay per day for days 6-90	In-Network \$300 co-pay per day for days 1-6 and a \$0 co-pay per day for days 7-90
Out-of-Network 20% of the total cost for days 1-90	Out-of-Network 35% of the total cost for days 1-90
What you should know Our plan covers a specified number of days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information.	What you should know Our plan covers a specified number of days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information.

Medical and Hospital Benefits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Outpatient Hospital Coverage ^{PA}	In-Network \$350 co-pay for surgical and non-surgical services Out-of-Network 40% coinsurance for surgical and non-surgical services What you should know Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient setting.	In-Network \$100 co-pay per non-surgical service / \$250 co-pay per surgical service Out-of-Network 35% coinsurance for surgical and non-surgical services What you should know Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient setting.
Outpatient Hospital Observation Services ^{PA}	In-Network \$90 co-pay Emergency Room (ER) / \$350 co-pay (Outpatient) Out-of-Network 40% coinsurance per stay What you should know Your cost for Outpatient Hospital Observation Services when you enter through ER or when you enter observation status through an outpatient setting.	In-Network \$90 co-pay Emergency Room (ER) / \$250 co-pay (Outpatient) Out-of-Network 35% coinsurance per stay What you should know Your cost for Outpatient Hospital Observation Services when you enter through ER or when you enter observation status through an outpatient setting.
Ambulatory Surgery Center (ASC) ^{PA}	In-Network \$250 co-pay Out-of-Network 40% coinsurance	In-Network \$200 co-pay Out-of-Network 35% coinsurance
Doctor Visits Primary Care Provider (PCP)	In-Network \$5 co-pay Out-of-Network \$5 co-pay	In-Network \$0 co-pay Out-of-Network \$25 co-pay

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$70 co-pay per non-surgical service / \$150 co-pay per surgical service Out-of-Network \$70 co-pay per non-surgical service / \$150 co-pay per surgical service What you should know Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient setting.	In-Network \$100 co-pay per non-surgical service / \$250 co-pay per surgical service Out-of-Network \$100 co-pay per non-surgical service / \$250 co-pay per surgical service What you should know Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient setting.
In-Network \$90 co-pay Emergency Room (ER) / \$150 co-pay (Outpatient) Out-of-Network \$90 co-pay Emergency Room (ER) / \$150 co-pay (Outpatient) What you should know Your cost for Outpatient Hospital Observation Services when you enter through ER or when you enter observation status through an outpatient setting.	In-Network \$90 co-pay Emergency Room (ER) / \$250 co-pay (Outpatient) Out-of-Network \$90 co-pay Emergency Room (ER) / \$250 co-pay (Outpatient) What you should know Your cost for Outpatient Hospital Observation Services when you enter through ER or when you enter observation status through an outpatient setting.
In-Network \$25 co-pay Out-of-Network \$25 co-pay	In-Network \$200 co-pay Out-of-Network \$200 co-pay
In-Network \$0 co-pay Out-of-Network \$0 co-pay	In-Network \$0 co-pay Out-of-Network \$0 co-pay

Medical and Hospital Benefits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
	What you should know Your PCP is the doctor who will handle most of your health care services. For telemedicine services rendered by your Primary Care Physician, Specialist, Urgent Needed Services, Outpatient Mental Health Care (Individual Session), Occupational Therapy, Physical Therapy and/or Speech-Language Therapy, Outpatient Substance Abuse (Individual Session), Podiatry Services (Medicare Covered), Home Health Agency Care, Diabetes Self-Management Training, Other Healthcare Professional, Walk-in and Pharmacy Clinics, you will pay the cost share for that provider listed throughout this document.	What you should know Your PCP is the doctor who will handle most of your health care services. For telemedicine services rendered by your Primary Care Physician, Specialist, Urgent Needed Services, Outpatient Mental Health Care (Individual Session), Occupational Therapy, Physical Therapy and/or Speech-Language Therapy, Outpatient Substance Abuse (Individual Session), Podiatry Services (Medicare Covered), Home Health Agency Care, Diabetes Self-Management Training, Other Healthcare Professional, Walk-in and Pharmacy Clinics, you will pay the cost share for that provider listed throughout this document.
Specialist ^{PA}	In-Network \$45 co-pay Out-of-Network \$45 co-pay	In-Network \$25 co-pay Out-of-Network \$50 co-pay
Other Healthcare Professionals ^{PA} (e.g. Physician Assistant or Nurse Practitioner)	In-Network \$5 co-pay (PCP office) \$45 co-pay (specialist office) \$45 co-pay (clinic/pharmacy setting) Out-of-Network \$5 co-pay (PCP office) \$45 co-pay (specialist office) \$45 co-pay (clinic/pharmacy setting)	In-Network \$0 co-pay (PCP office) \$25 co-pay (specialist office) \$25 co-pay (clinic/pharmacy setting) Out-of-Network \$25 co-pay (PCP Office) \$50 co-pay (specialist office) \$50 co-pay (clinic/pharmacy setting)
Teladoc	You pay a \$0 co-pay per call What you should know Participating providers may diagnose and treat some medical conditions via real-time interactive audio and video technologies.	You pay a \$0 co-pay per call What you should know Participating providers may diagnose and treat some medical conditions via real-time interactive audio and video technologies.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
What you should know Your PCP is the doctor who will handle most of your health care services. For telemedicine services rendered by your Primary Care Physician, Specialist, Urgent Needed Services, Outpatient Mental Health Care (Individual Session), Occupational Therapy, Physical Therapy and/or Speech-Language Therapy, Outpatient Substance Abuse (Individual Session), Podiatry Services (Medicare Covered), Home Health Agency Care, Diabetes Self-Management Training, Other Healthcare Professional, Walk-in and Pharmacy Clinics, you will pay the cost share for that provider listed throughout this document.	What you should know Your PCP is the doctor who will handle most of your health care services. For telemedicine services rendered by your Primary Care Physician, Specialist, Urgent Needed Services, Outpatient Mental Health Care (Individual Session), Occupational Therapy, Physical Therapy and/or Speech-Language Therapy, Outpatient Substance Abuse (Individual Session), Podiatry Services (Medicare Covered), Home Health Agency Care, Diabetes Self-Management Training, Other Healthcare Professional, Walk-in and Pharmacy Clinics, you will pay the cost share for that provider listed throughout this document.
In-Network \$40 co-pay Out-of-Network \$40 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay
In-Network \$0 co-pay (PCP office) \$40 co-pay (specialist office) \$40 co-pay (clinic/pharmacy setting) Out-of-Network \$0 co-pay (PCP Office) \$40 co-pay (specialist office) \$40 co-pay (clinic/pharmacy setting)	In-Network \$0 co-pay (PCP office) \$30 co-pay (specialist office) \$30 co-pay (clinic/pharmacy setting) Out-of-Network \$0 co-pay (PCP Office) \$30 co-pay (specialist office) \$30 co-pay (clinic/pharmacy setting)
You pay a \$0 co-pay per call What you should know Participating providers may diagnose and treat some medical conditions via real-time interactive audio and video technologies.	You pay a \$0 co-pay per call What you should know Participating providers may diagnose and treat some medical conditions via real-time interactive audio and video technologies.

Emergency Care / Urgently Needed Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Emergency Care	\$90 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	\$90 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Worldwide Emergency Coverage	\$90 co-pay What you should know 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 not waived if admitted to the hospital for WW Emergency Services.	\$90 co-pay What you should know 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 not waived if admitted to the hospital for WW Emergency Services.
Urgently Needed Services	\$40 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	\$30 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
Worldwide Urgent Coverage	\$90 co-pay What you should know Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for WW Urgently Needed Services.	\$90 co-pay What you should know Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for WW Urgently Needed Services.

Diagnostic Services / Labs / Imaging	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Lab Services^{PA} (Medicare approved lab work)	In-Network \$0 co-pay Out-of-Network 40% coinsurance	In-Network \$0 co-pay Out-of-Network 35% coinsurance

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
\$90 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	\$90 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
\$90 co-pay What you should know 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 not waived if admitted to the hospital for WW Emergency Services.	\$90 co-pay What you should know 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 not waived if admitted to the hospital for WW Emergency Services.
\$30 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	\$30 co-pay What you should know If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
\$90 co-pay What you should know Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for WW Urgently Needed Services.	\$90 co-pay What you should know Worldwide Emergency and worldwide urgently needed services are subject to a \$50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for WW Urgently Needed Services.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$0 co-pay Out-of-Network \$0 co-pay	In-Network \$0 co-pay Out-of-Network \$0 co-pay

Diagnostic Services / Labs / Imaging	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Diagnostic Radiology Services^{PA} (MRI/CT/PET scans in specialist office or free standing facility / outpatient setting)	In-Network \$350 co-pay Out-of-Network 40% coinsurance What you should know You pay \$0 for mammograms and DEXA scans.	In-Network \$100 co-pay Out-of-Network 35% coinsurance What you should know You pay \$0 for mammograms and DEXA scans.
Diagnostic Tests and Procedures^{PA} (Basic / Advanced)	In-Network \$0 co-pay \$40 co-pay Out-of-Network 40% coinsurance	In-Network \$0 co-pay Out-of-Network 35% coinsurance
Therapeutic Radiology Services^{PA} (radiation treatment for cancer in a specialist office or free standing facility / outpatient setting)	In-Network 20% coinsurance Out-of-Network 40% coinsurance	In-Network 20% coinsurance Out-of-Network 35% coinsurance
Outpatient X-Ray^{PA}	In-Network \$0 co-pay Out-of-Network 40% coinsurance	In-Network \$0 co-pay Out-of-Network 35% coinsurance

Hearing Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Hearing Exam^{PA} (Medicare Covered)	In-Network \$45 co-pay Out-of-Network \$45 co-pay	In-Network \$25 co-pay Out-of-Network \$50 co-pay

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$50 co-pay / \$70 co-pay Out-of-Network \$50 co-pay / \$70 co-pay What you should know You pay \$0 for mammograms and DEXA scans.	In-Network \$100 co-pay Out-of-Network \$100 co-pay What you should know You pay \$0 for mammograms and DEXA scans.
In-Network \$0 co-pay \$20 co-pay Out-of-Network \$0 co-pay \$20 co-pay	In-Network \$0 co-pay \$25 co-pay Out-of-Network \$0 co-pay \$25 co-pay
In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance
In-Network \$0 co-pay Out-of-Network \$0 co-pay	In-Network \$0 co-pay Out-of-Network \$0 co-pay

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$40 co-pay Out-of-Network \$40 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay

Hearing Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Routine Hearing Exam ^{PA}	In-Network \$0 co-pay 1 exam every year Out-of-Network 40% coinsurance 1 exam every year	In-Network \$0 co-pay 1 exam every year Out-of-Network 40% coinsurance 1 exam every year
Hearing Aid Fitting/Evaluations ^{PA}	In-Network \$0 co-pay 1 fitting(s)/evaluation(s) every year Out-of-Network 40% coinsurance 1 fitting(s)/evaluation(s) every year	In-Network \$0 co-pay 1 fitting(s)/evaluation(s) every year Out-of-Network 40% coinsurance 1 fitting(s)/evaluation(s) every year
Annual Hearing Aid Allowance ^{PA}	In-Network \$0 co-pay 2 hearing aids per year \$700 value Out-of-Network 40% coinsurance 2 hearing aids per year \$700 value What you should know 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.	In-Network \$0 co-pay 2 hearing aids per year \$1,000 value Out-of-Network 40% coinsurance 2 hearing aids per year \$1,000 value What you should know 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.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$0 co-pay 1 exam every year Out-of-Network 40% coinsurance 1 exam every year	In-Network \$0 co-pay 1 exam every year Out-of-Network 40% coinsurance 1 exam every year
In-Network \$0 co-pay 1 fitting(s)/evaluation(s) every year Out-of-Network 40% coinsurance 1 fitting(s)/evaluation(s) every year	In-Network \$0 co-pay 1 fitting(s)/evaluation(s) every year Out-of-Network 40% coinsurance 1 fitting(s)/evaluation(s) every year
In-Network \$0 co-pay 2 hearing aids per year \$1,500 value Out-of-Network 40% coinsurance 2 hearing aids per year \$1,500 value What you should know 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.	In-Network \$0 co-pay 2 hearing aids per year \$1,000 value Out-of-Network 40% coinsurance 2 hearing aids per year \$1,000 value What you should know 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.

Dental Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Preventive Services ^{PA}	In-Network \$0 co-pay for: Cleanings (1 every 6 months) Dental x-rays (1 every 12 to 36 months) Oral exams (1 every 6 months) Out-of-Network 50% coinsurance for Cleanings (1 every 6 months) Dental x-rays 1 (Every 12 to 36 months) Oral exams (1every 6 months)	In-Network \$0 co-pay for: Cleanings (1 every 6 months) Dental x-rays (1 every 12 to 36 months) Oral exams (1 every 6 months) Out-of-Network 50% coinsurance for Cleanings (1 every 6 months) Dental x-rays 1 (Every 12 to 36 months) Oral exams (1 every 6 months)
Fluoride ^{PA}	In-Network \$0 co-pay (1 every year) Out-of-Network 50% coinsurance (1 every year)	In-Network \$0 co-pay (1 every year) Out-of-Network 50% coinsurance (1 every year)
Comprehensive Services ^{PA} (Medicare-Covered)	In-Network \$45 co-pay Out-of-Network \$45 co-pay	In-Network \$25 co-pay Out-of-Network \$50 co-pay
Comprehensive Services ^{PA}		
Routine Services	In-Network \$0 co-pay Out-of-Network 50% coinsurance	In-Network \$0 co-pay Out-of-Network 50% coinsurance
Restorative	1 every three years	1 every three years
Endodontics	1 Endodontic procedure per tooth	1 Endodontic procedure per tooth
Periodontics	1 Periodontic procedure every 6 to 36 months	1 Periodontic procedure every 6 to 36 months
Extractions	1 Extraction per tooth	1 Extraction per tooth
Non-Routine Services	1 Non-Routine Services every 6 to 24 months	1 Non-Routine Services every 6 to 24 months

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$0 co-pay for: Cleanings (1 every 6 months) Dental x-rays (1 every 12 to 36 months) Oral exams (1 every 6 months) Out-of-Network 50% coinsurance for Cleanings (1 every 6 months) Dental x-rays 1 (Every 12 to 36 months) Oral exams (1 every 6 months)	In-Network \$0 co-pay for: Cleanings (1 every 6 months) Dental x-rays (1 every 12 to 36 months) Oral exams (1 every 6 months) Out-of-Network 50% coinsurance for Cleanings (1 every 6 months) Dental x-rays 1 (Every 12 to 36 months) Oral exams (1 every 6 months)
In-Network \$0 co-pay (1 every year) Out-of-Network 50% coinsurance (1 every year)	In-Network \$0 co-pay (1 every year) Out-of-Network 50% coinsurance (1 every year)
In-Network \$40 co-pay Out-of-Network \$40 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay
In-Network \$0 co-pay Out-of-Network 50% coinsurance	In-Network \$0 co-pay Out-of-Network 50% coinsurance
1 every three years	1 every three years
1 Endodontic procedure per tooth	1 Endodontic procedure per tooth
1 Periodontic procedure every 6 to 36 months	1 Periodontic procedure every 6 to 36 months
1 Extraction per tooth	1 Extraction per tooth
1 Non-Routine Services every 6 to 24 months	1 Non-Routine Services every 6 to 24 months

Dental Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Prosthodontics, Other Oral/ Maxillofacial Surgery	1 Prosthodontic procedure every 12 to 60 months 1 Oral Maxillofacial procedure every 60 months or per lifetime Other services every 6 to 24 months What you should know This plan includes coverage of preventive and comprehensive services up to \$1,000 , including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge or a crown and a root canal.	1 Prosthodontic procedure every 12 to 60 months 1 Oral Maxillofacial procedure every 60 months or per lifetime Other services every 6 to 24 months What you should know This plan includes coverage of preventive and comprehensive services up to \$1,000 , including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge or a crown and a root canal.

Vision Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Eye Exams ^{PA} (Medicare Covered)	In-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$45 co-pay (all other Medicare-covered eye exams) Out-of-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$45 co-pay (all other Medicare-covered eye exams)	In-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$25 co-pay (all other Medicare-covered eye exams) Out-of-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$50 co-pay (all other Medicare-covered eye exams)
Routine Eye Exams (Refraction) ^{PA}	In-Network \$0 co-pay 1 exam per year Out-of-Network 40% coinsurance 1 exam per year	In-Network \$0 co-pay 1 exam per year Out-of-Network 40% coinsurance 1 exam per year
Glaucoma Screening	In-Network \$0 co-pay Out-of-Network \$0 co-pay	In-Network \$0 co-pay Out-of-Network \$0 co-pay

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
1 Prosthodontic procedure every 12 to 60 months 1 Oral Maxillofacial procedure every 60 months or per lifetime Other services every 6 to 24 months What you should know This plan includes coverage of preventive and comprehensive services up to \$1,000 , including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge or a crown and a root canal.	1 Prosthodontic procedure every 12 to 60 months 1 Oral Maxillofacial procedure every 60 months or per lifetime Other services every 6 to 24 months What you should know This plan includes coverage of preventive and comprehensive services up to \$1,000 , including but not limited to cleanings, x-ray(s), oral exams, fluoride treatments, fillings, dentures or a bridge or a crown and a root canal.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$40 co-pay (all other Medicare-covered eye exams) Out-of-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$40 co-pay (all other Medicare-covered eye exams)	In-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$30 co-pay (all other Medicare-covered eye exams) Out-of-Network \$0 co-pay (Medicare-covered diabetes retinopathy screening) \$30 co-pay (all other Medicare-covered eye exams)
In-Network \$0 co-pay 1 exam per year Out-of-Network 40% coinsurance 1 exam per year	In-Network \$0 co-pay 1 exam per year Out-of-Network 40% coinsurance 1 exam per year
In-Network \$0 co-pay Out-of-Network \$0 co-pay	In-Network \$0 co-pay Out-of-Network \$0 co-pay

Vision Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Eyewear^{PA} (Medicare Covered)	In-Network \$0 co-pay Out-of-Network \$45 co-pay	In-Network \$0 co-pay Out-of-Network \$50 co-pay
Contact Lenses, Eye Glasses, Eye Glass Lenses, Eye Glass Frames^{PA}	In-Network \$0 co-pay Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100 Out-of-Network 40% coinsurance Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100	In-Network \$0 co-pay Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100 Out-of-Network 40% coinsurance Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100

Mental Health Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Inpatient Mental Health Services^{PA}	In-Network \$1,750 co-pay per stay Out-of-Network 40% of the total cost for days 1-90 What you should know Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	In-Network \$350 co-pay per day for days 1-5 and a \$0 co-pay per day for days 6-90 Out-of-Network 35% of the total cost for days 1-90 What you should know Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.
Outpatient Mental Health Services^{PA} Per session for individual therapy	In-Network \$40 co-pay Out-of-Network 40% coinsurance	In-Network \$40 co-pay Out-of-Network 35% coinsurance

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$0 co-pay Out-of-Network \$40 co-pay	In-Network \$0 co-pay Out-of-Network \$30 co-pay
In-Network \$0 co-pay Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100 Out-of-Network 40% coinsurance Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100	In-Network \$0 co-pay Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100 Out-of-Network 40% coinsurance Unlimited contacts Unlimited glasses (lenses and/or frames) per year Up to \$100

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$575 co-pay per day for days 1-3 and a \$0 co-pay per day for days 4-90 Out-of-Network 35% of the total cost for days 1-90 What you should know Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	In-Network \$350 co-pay per day for days 1-5 and a \$0 co-pay per day for days 6-90 Out-of-Network 35% of the total cost for days 1-90 What you should know Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.
In-Network \$40 co-pay Out-of-Network \$40 co-pay	In-Network \$40 co-pay Out-of-Network \$40 co-pay

Mental Health Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Per session for group therapy	In-Network \$40 co-pay Out-of-Network 40% coinsurance	In-Network \$40 co-pay Out-of-Network 35% coinsurance
Partial Hospitalization ^{PA}	In-Network \$55 co-pay Out-of-Network 40% coinsurance	In-Network \$55 co-pay Out-of-Network 35% coinsurance

Skilled Nursing Facility (SNF)	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Skilled Nursing Facility (SNF) ^{PA}	In-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 Out-of-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 What you should know Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a SNF and ends when you haven’t received any SNF care for 60 consecutive days. There is no limit to the number of benefit periods you may have.	In-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 Out-of-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 What you should know Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a SNF and ends when you haven’t received any SNF care for 60 consecutive days. There is no limit to the number of benefit periods you may have.

Therapy and Rehabilitation Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Physical Therapy and Speech-Language Therapy ^{PA}	In-Network \$40 co-pay Out-of-Network 40% coinsurance	In-Network \$40 co-pay Out-of-Network 35% coinsurance

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$40 co-pay Out-of-Network \$40 co-pay	In-Network \$40 co-pay Out-of-Network \$40 co-pay
In-Network \$55 co-pay Out-of-Network \$55 co-pay	In-Network \$55 co-pay Out-of-Network \$55 co-pay

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 Out-of-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 What you should know Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a SNF and ends when you haven’t received any SNF care for 60 consecutive days. There is no limit to the number of benefit periods you may have.	In-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 Out-of-Network \$0 co-pay per day for days 1-20 and a \$184.00 co-pay per day for days 21-100 What you should know Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a SNF and ends when you haven’t received any SNF care for 60 consecutive days. There is no limit to the number of benefit periods you may have.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$30 co-pay Out-of-Network \$30 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay

Therapy and Rehabilitation Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Occupational Therapy ^{PA}	In-Network \$40 co-pay Out-of-Network 40% coinsurance	In-Network \$40 co-pay Out-of-Network 35% coinsurance
Cardiac Rehabilitation ^{PA}	In-Network \$30 co-pay Out-of-Network 40% coinsurance	In-Network \$30 co-pay Out-of-Network 35% coinsurance
Pulmonary Rehabilitation ^{PA}	In-Network \$30 co-pay Out-of-Network 40% coinsurance	In-Network \$30 co-pay Out-of-Network 35% coinsurance
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) ^{PA}	In-Network \$30 co-pay Out-of-Network 40% coinsurance	In-Network \$30 co-pay Out-of-Network 35% coinsurance

Ambulance and Transportation	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Ambulance ^{PA}	(ground / air) \$210 co-pay	(ground / air) \$250 co-pay
Transportation ^{PA}	In-Network Not Covered Out-of-Network Not Covered	In-Network Not Covered Out-of-Network Not Covered

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$30 co-pay Out-of-Network \$30 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay
In-Network \$30 co-pay Out-of-Network \$30 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay
In-Network \$30 co-pay Out-of-Network \$30 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay
In-Network \$30 co-pay Out-of-Network \$30 co-pay	In-Network \$30 co-pay Out-of-Network \$30 co-pay

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
(ground / air) \$285 co-pay	(ground / air) \$250 co-pay
In-Network \$0 co-pay for 24 one-way trips every year Out-of-Network 75% coinsurance 24 one-way trips every year What you should know The first step to staying healthy is getting to your doctor. That’s why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need, when you need it. Call Customer Service 72 hours in advance to reserve a ride for your appointment.	In-Network Not Covered Out-of-Network Not Covered

Medicare Part B Drugs	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Medicare Part B Drugs ^{PA}	In-Network 20% coinsurance Out-of-Network 40% coinsurance What you should know Includes chemotherapy and other Part B drugs	In-Network 20% coinsurance Out-of-Network 35% coinsurance What you should know Includes chemotherapy and other Part B drugs

Prescription Drug Coverage	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Part D Deductible	\$200 Tiers 2 to 5	\$100 Tiers 3 to 5
Initial Coverage Stage (after you pay your deductible if applicable)	After you pay your deductible, You pay these co-pays or coinsurance amounts until your total yearly drug cost reaches \$4,130 . Total yearly drug costs are the total drug costs paid by both you and our Part D plan at network retail pharmacies and mail order pharmacies.	After you pay your deductible, You pay these co-pays or coinsurance amounts until your total yearly drug cost reaches \$4,130 . Total yearly drug costs are the total drug costs paid by both you and our Part D plan at network retail pharmacies and mail order pharmacies.
Standard Retail, Mail and Preferred Mail Cost-Share (In-Network)		
Tier 1: Preferred Generic Drugs		
Standard Retail and Mail - 30 day supply	\$0.00	\$0.00
Standard Retail and Mail - 90 day supply	\$0.00	\$0.00
Preferred Mail - 30 day supply	\$0.00	\$0.00
Preferred Mail - 90 day supply	\$0.00	\$0.00
Tier 2: Generic Drugs		
Standard Retail and Mail - 30 day supply	\$15.00	\$7.00
Standard Retail and Mail - 90 day supply	\$45.00	\$21.00
Preferred Mail - 30 day supply	\$15.00	\$7.00
Preferred Mail - 90 day supply	\$0.00	\$0.00
Tier 3: Preferred Brand Drugs		

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network 20% coinsurance Out-of-Network 20% coinsurance What you should know Includes chemotherapy and other Part B drugs	In-Network 20% coinsurance Out-of-Network 20% coinsurance What you should know Includes chemotherapy and other Part B drugs

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
\$445 Tiers 2 to 5	Not Covered
After you pay your deductible, You pay these co-pays or coinsurance amounts until your total yearly drug cost reaches \$4,130 . Total yearly drug costs are the total drug costs paid by both you and our Part D plan at network retail pharmacies and mail order pharmacies.	Not Covered
\$0.00	Not Covered
\$0.00	Not Covered
\$0.00	Not Covered
\$0.00	Not Covered
\$20.00	Not Covered
\$60.00	Not Covered
\$20.00	Not Covered
\$0.00	Not Covered

Prescription Drug Coverage	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Standard Retail and Mail - 30 day supply	\$47.00	\$47.00
Standard Retail and Mail - 90 day supply	\$141.00	\$141.00
Preferred Mail - 30 day supply	\$47.00	\$47.00
Preferred Mail - 90 day supply	\$94.00	\$94.00
Tier 4: Non-Preferred Drugs		
Standard Retail and Mail - 30 day supply	\$100.00	50%
Standard Retail and Mail - 90 day supply	\$300.00	50%
Preferred Mail - 30 day supply	\$100.00	50%
Preferred Mail - 90 day supply	\$200.00	50%
Tier 5: Specialty Tier Drugs		
Standard Retail and Mail - 30 day supply	29%	31%
Preferred Mail - 30 day supply	29%	31%

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
\$47.00	Not Covered
\$141.00	Not Covered
\$47.00	Not Covered
\$94.00	Not Covered
50%	Not Covered
50%	Not Covered
50%	Not Covered
50%	Not Covered
25%	Not Covered
25%	Not Covered

Prescription Drug Coverage	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC	WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
What you should know	<p><u>Preferred Mail:</u> 90-day supply of Tier 1 and Tier 2 prescription drugs for a \$0 co-pay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day co-pays, if applicable. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and co-pays.</p> <p><u>Standard Retail and Mail:</u> You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan’s cost of the drug minus the co-pay or coinsurance for drugs purchased out-of-network until your total yearly drug costs reach \$4,130. You will likely have to pay the pharmacy’s full charge for the drugs and submit documentation to receive reimbursement. Cost-sharing may change depending on the pharmacy you use and when you move from one phase of the Part D benefit to another, your cost-sharing may change as well. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.</p> <p><u>Excluded Drugs:</u> This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil and Vardenafil on Tier 1 have a quantity limit of four pills every 30 days.</p>	<p><u>Preferred Mail:</u> 90-day supply of Tier 1 and Tier 2 prescription drugs for a \$0 co-pay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day co-pays, if applicable. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and co-pays.</p> <p><u>Standard Retail and Mail:</u> You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan’s cost of the drug minus the co-pay or coinsurance for drugs purchased out-of-network until your total yearly drug costs reach \$4,130. You will likely have to pay the pharmacy’s full charge for the drugs and submit documentation to receive reimbursement. Cost-sharing may change depending on the pharmacy you use and when you move from one phase of the Part D benefit to another, your cost-sharing may change as well. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.</p> <p><u>Excluded Drugs:</u> This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil and Vardenafil on Tier 1 have a quantity limit of four pills every 30 days.</p>	<p><u>Preferred Mail:</u> 90-day supply of Tier 1 and Tier 2 prescription drugs for a \$0 co-pay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day co-pays, if applicable. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and co-pays.</p> <p><u>Standard Retail and Mail:</u> You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan’s cost of the drug minus the co-pay or coinsurance for drugs purchased out-of-network until your total yearly drug costs reach \$4,130. You will likely have to pay the pharmacy’s full charge for the drugs and submit documentation to receive reimbursement. Cost-sharing may change depending on the pharmacy you use and when you move from one phase of the Part D benefit to another, your cost-sharing may change as well. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.</p> <p><u>Excluded Drugs:</u> This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil and Vardenafil on Tier 1 have a quantity limit of four pills every 30 days. Because these drug 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.</p>	Not Covered

Prescription Drug Coverage	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC	WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
	Because these drug 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.	Because these drug 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.		
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130 . After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your out-of-pocket costs total \$6,550 which is the end of the coverage gap. You will pay \$0.00 for 30-day Standard Retail, \$0.00 for 90-day Standard Retail and \$0.00 for 90-day Preferred Mail for select drugs on Tier 1. The standard gap cost-share of 25% will apply for all other brand name drugs and 25% for generic drugs. Please call us or access your plan Evidence of Coverage and Formulary for details of which drugs are covered through the Coverage Gap Stage.	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130 . After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your out-of-pocket costs total \$6,550 which is the end of the coverage gap.	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130 . After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your out-of-pocket costs total \$6,550 which is the end of the coverage gap.	Not Covered

Additional Covered Benefits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Opioid Treatment Services ^{PA}	In-Network \$45 co-pay Out-of-Network \$45 co-pay What you should know Opioid treatment services include FDA-approved opioid agonist and antagonist treatment medications, substance counseling and individual and/or group therapy.	In-Network \$25 co-pay Out-of-Network \$50 co-pay What you should know Opioid treatment services include FDA-approved opioid agonist and antagonist treatment medications, substance counseling and individual and/or group therapy.
Renal Dialysis	In-Network 20% coinsurance Out-of-Network 40% coinsurance	In-Network 20% coinsurance Out-of-Network 35% coinsurance
Over-The-Counter (OTC) Health Items	The maximum total annual benefit is \$100. What you should know Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.	The maximum total annual benefit is \$340. What you should know Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.
In-Home Support Services^{PA}	Not Covered	Not Covered
Meals Post-Acute Meals ^{PA} Chronic Meals ^{PA}	\$0 co-pay for each post-acute meal What you should know You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days. \$0 co-pay for each chronic meal	\$0 co-pay for each post-acute meal What you should know You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days. \$0 co-pay for each chronic meal

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network \$40 co-pay Out-of-Network \$40 co-pay What you should know Opioid treatment services include FDA-approved opioid agonist and antagonist treatment medications, substance counseling and individual and/or group therapy.	In-Network \$30 co-pay Out-of-Network \$30 co-pay What you should know Opioid treatment services include FDA-approved opioid agonist and antagonist treatment medications, substance counseling and individual and/or group therapy.
In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance
The maximum total annual benefit is \$200. What you should know Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.	The maximum total annual benefit is \$240. What you should know Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.
\$0 co-pay Up to 12 visits every year. Chores and Personal Care Services, include: You can receive Chore and Personal Care Services if you meet certain clinical criteria. Services must be recommended or requested by a licensed plan clinician or a licenses plan provider. Services are provided in four hour increments.	Not Covered
\$0 co-pay for each post-acute meal What you should know You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days. \$0 co-pay for each chronic meal	\$0 co-pay for each post-acute meal What you should know You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days. \$0 co-pay for each chronic meal

Additional Covered Benefits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
	What you should know You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modification. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months	What you should know You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modification. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months.

Medical Equipment / Supplies / Services	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Durable Medical Equipment (DME) ^{PA} (e.g., wheelchairs, oxygen)	In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance
Prosthetics ^{PA} (e.g., braces, artificial limbs)	In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance
Diabetic Monitoring Supplies ^{PA}	In-Network \$0 co-pay Out-of-Network 20% coinsurance What you should know Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions.	In-Network \$0 co-pay Out-of-Network 20% coinsurance What you should know Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions.
Medical Supplies ^{PA}	In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
What you should know You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modification. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months.	What you should know You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modification. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months.

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance
In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance
In-Network \$0 co-pay Out-of-Network \$0 co-pay What you should know Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions.	In-Network \$0 co-pay Out-of-Network \$0 co-pay What you should know Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions.
In-Network 20% coinsurance Out-of-Network 20% coinsurance	In-Network 20% coinsurance Out-of-Network 20% coinsurance

Wellness Programs	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Personal Emergency Response System (PERS) ^{PA}	\$0 co-pay	\$0 co-pay
Additional Routine Annual Physical	In-Network \$0 co-pay Out-of-Network \$0 co-pay What you should know Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.	In-Network \$0 co-pay Out-of-Network \$0 co-pay What you should know Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.
24-Hour Nurse Advice Line	\$0 co-pay	\$0 co-pay

Additional Supplemental Benefits	WellCare Absolute (PPO) H7175004000 NC	WellCare Premier (PPO) H7175001000 NC
Flex Card	Not Covered	Not Covered

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
\$0 co-pay	\$0 co-pay
In-Network \$0 co-pay Out-of-Network \$0 co-pay What you should know Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.	In-Network \$0 co-pay Out-of-Network \$0 co-pay What you should know Wellness programs are a great way to maintain your health. Whether it's an extra checkup during the year or you just have a simple health question, we are here as your partner in health.
\$0 co-pay	\$0 co-pay

WellCare Summit (PPO) H7175003000 NC	WellCare Patriot (PPO) H7175005000 NC
\$200 yearly benefit What you should know The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier.	\$500 yearly benefit What you should know The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier.

WellCare Health Plans, Inc., is an HMO, PPO, PFFS plan with a Medicare contract. Enrollment in the plans depend on contract renewal. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. Our plans use a formulary.

You have the choice to sign up for automated mail service delivery. You can get prescription drugs shipped to your home through our network mail service delivery program. You should expect to receive your prescription drugs within 10–14 calendar days from the time that the mail service pharmacy receives the order. If you do not receive your prescription drugs within this time, please contact us at 1-866-808-7471 (TTY/TDD 711), 24 hours a day, seven days a week, or visit mailrx.wellcare.com.

Out-of-network/non-contracted providers are under no obligation to treat WellCare 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. Please contact your plan for details.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-374-4056** (TTY/TDD: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-374-4056** (TTY/TDD: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-374-4056** (TTY/TDD: **711**)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-374-4056** (TTY/TDD: **711**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-374-4056** (TTY/TDD: **711**)번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-374-4056** (TTY/TDD: **711**).

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 **1-866-527-0056** (TTY/TDD 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.wellcare.com/medicare or call 1-866-527-0056 to view a copy of the EOC.
- ☐ 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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 co-payments/coinsurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.





Contact Us



For more information, please call us at the phone number below or visit us at www.wellcare.com/medicare.

- Not yet a member? Please call us toll-free at **1-866-527-0056** (TTY/TDD 711). Your call may be answered by a licensed agent.
- Already a member? Please call us toll-free at **1-833-444-9088** (TTY/TDD 711).



Hours of Operation

- Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m.
- Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.



Formularies and Directories

You can see our plan's Provider/Pharmacy Directory and our complete plan formulary (list of Part D prescription drugs) at our website: www.wellcare.com/medicare. Or, call us and we'll send you a copy. We're with our members every step of the way.

