



# 2026 Summary of Benefits

Texas

## **Wellcare Giveback (HMO)**

H0174 | 019 | 000

## **Wellcare Simple (HMO)**

H0174 | 010 | 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) and Wellcare Simple (HMO) 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 Texas Department of Health and Human Services or by another third party.

**Plan's service areas:**

**H0174019000 Wellcare Giveback (HMO)** includes these counties in Texas: Austin, Chambers, Fort Bend, Galveston, Hardin, Harris, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Walker, Waller, and Wharton.

**H0174010000 Wellcare Simple (HMO)** includes these counties in Texas: Austin, Chambers, Fort Bend, Galveston, Hardin, Harris, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Walker, Waller, and Wharton.

**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.

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) and Wellcare Simple (HMO) 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) and Wellcare Simple (HMO) have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

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 H0174019000 Wellcare Giveback (HMO): [go.wellcare.com/druglist-6720](https://go.wellcare.com/druglist-6720); H0174010000 Wellcare Simple (HMO): [go.wellcare.com/druglist-6718](https://go.wellcare.com/druglist-6718).

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

|                                                                                                                                             | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                            | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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.                                                                                                                                                            |
| <b>Part B Premium Reduction</b>                                                                                                             | This plan offers a \$109 give back every month in your Social Security check.                                                                                              | <u>Not</u> Available                                                                                                                                                                                                         |
| <b>Deductible</b>                                                                                                                           | \$205 deductible for select Part B services                                                                                                                                | No deductible for medical.<br>See prescription drugs section for Part D deductible.                                                                                                                                          |
| <b>Maximum Out-of-Pocket (MOOP) Responsibility</b><br>(does not include prescription drugs)                                                 | \$6,900 annually<br>This is the most you will pay in copays and coinsurance for Part A and B services for the year.                                                        | \$3,500 annually<br>This is the most you will pay in copays and coinsurance for Part A and B services for the year.                                                                                                          |
| <b>Inpatient Hospital Coverage</b>                                                                                                          | For each admission, you pay: <ul style="list-style-type: none"> <li>\$395 copay per day for days 1 through 5</li> <li>\$0 copay per day for days 6 through 90</li> </ul> * | For each admission, you pay: <ul style="list-style-type: none"> <li>\$325 copay per day for days 1 through 6</li> <li>\$0 copay per day for days 7 through 90</li> <li>\$0 copay per day for days 91 through 95</li> </ul> * |

## Benefits

|                                                  | <b>Wellcare Giveback (HMO)<br/>H0174, Plan 019, 000</b>                                                                                                                                                                           | <b>Wellcare Simple (HMO)<br/>H0174, Plan 010, 000</b>                                                                                                                                                                             |
|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Outpatient Hospital Coverage</b>              |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |
| Outpatient Hospital Services                     | \$0 copay for skin biopsies.<br>\$350 copay for outpatient surgical services.<br>\$300 copay for outpatient non-surgical services, including outpatient palliative care.<br>*                                                     | \$0 copay for skin biopsies.<br>\$280 copay for outpatient surgical services.<br>\$150 copay for outpatient non-surgical services, including outpatient palliative care.<br>*                                                     |
| Outpatient Hospital Observation Services         | \$115 copay for outpatient observation services when you enter observation status through an emergency room.<br>\$350 copay for outpatient observation services when you enter observation status through an outpatient facility. | \$150 copay for outpatient observation services when you enter observation status through an emergency room.<br>\$280 copay for outpatient observation services when you enter observation status through an outpatient facility. |
| <b>Ambulatory Surgical Center (ASC) Services</b> | \$225 copay for each Medicare-covered visit to an ambulatory surgical center.<br>*                                                                                                                                                | \$75 copay for each Medicare-covered visit to an ambulatory surgical center.<br>*                                                                                                                                                 |
| <b>Doctor Visits</b>                             |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |
| Primary Care Providers                           | \$0 copay                                                                                                                                                                                                                         | \$0 copay                                                                                                                                                                                                                         |
| Specialists                                      | \$50 copay<br>*                                                                                                                                                                                                                   | \$15 copay<br>*                                                                                                                                                                                                                   |

## Benefits

|                                                                                                                                                                                                                                                                                                                                                                                                    | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                                                                                                                    | Wellcare Simple (HMO)<br>H0174, Plan 010, 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                                                                                                                                                                                                                                                                                                                          |
| <b>Emergency Care</b>                                                                                                                                                                                                                                                                                                                                                                              | \$115 copay<br>Copay is waived if you are admitted to a hospital within 24 hours.                                                                                                                                                                                                                                                  | \$150 copay<br>Copay is waived if you are admitted to a hospital within 24 hours.                                                                                                                                                                                                                                                  |
| Worldwide Emergency Coverage                                                                                                                                                                                                                                                                                                                                                                       | \$115 copay<br><br>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. | \$150 copay<br><br>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. |

## Benefits

|                                                    | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                   | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                                                                     |
|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Urgently Needed Services</b>                    | \$30 copay<br>Copay is waived if you are admitted to a hospital within 24 hours.                                                                                                                                                  | \$20 copay<br>Copay is waived if you are admitted to a hospital within 24 hours.                                                                                                                                                  |
| Worldwide Urgent Care Coverage                     | \$115 copay<br><br>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. | \$150 copay<br><br>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. |
| <b>Diagnostic Services/Labs/Imaging</b>            |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |
| Lab Services                                       | \$0 for labs related to A1C and kidney health evaluation.<br>\$50 copay for genetic testing.<br>\$10 copay for all other labs.<br>*                                                                                               | \$50 copay for genetic testing.<br>\$0 copay for all other labs.<br>*                                                                                                                                                             |
| Diagnostic Tests and Procedures                    | \$0 copay for Medicare-covered diagnostic colonoscopy, spirometry testing and specified testing related services.<br>\$30 copay for all other services.<br>*                                                                      | \$0 copay for Medicare-covered diagnostic colonoscopy, spirometry testing and specified testing related services.<br>\$25 copay for all other services.<br>*                                                                      |
| Outpatient X-rays                                  | \$50 copay<br>*                                                                                                                                                                                                                   | \$25 copay<br>*                                                                                                                                                                                                                   |
| Diagnostic Radiology Services (e.g. MRI, CAT Scan) | \$0 copay for a diagnostic mammogram.                                                                                                                                                                                             | \$0 copay for a diagnostic mammogram.                                                                                                                                                                                             |

## Benefits

|                                      | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                        | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
|                                      | \$300 copay for all other diagnostic radiology services received in an outpatient setting.<br>\$200 copay for all other services received in all other locations.<br>* | \$150 copay for all other diagnostic radiology services.<br>*    |
| Therapeutic Radiology                | 20% coinsurance<br>*                                                                                                                                                   | 20% coinsurance<br>*                                             |
| <b>Hearing Services</b>              |                                                                                                                                                                        |                                                                  |
| Hearing Exam<br>Medicare-covered     | \$50 copay<br>*                                                                                                                                                        | \$15 copay<br>*                                                  |
| Routine Hearing Exam                 | \$0 copay<br>*<br><br>1 exam(s) every year                                                                                                                             | \$0 copay<br>*<br><br>1 exam(s) every year                       |
| Hearing Aids                         |                                                                                                                                                                        |                                                                  |
| Hearing Aid<br>Fitting/Evaluation(s) | \$0 copay<br>*<br><br>1 fitting(s) / evaluation(s)<br>every year                                                                                                       | \$0 copay<br>*<br><br>1 fitting(s) / evaluation(s)<br>every year |

## Benefits

|                                                | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                           | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                             |
|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hearing Aid Allowance<br>All Types             | Up to a \$350 allowance per ear every year for hearing aids.<br><br>\$0 copay<br>*<br><br>Limited to 2 hearing aid(s) every year                                                          | Up to a \$750 allowance per ear every year for hearing aids.<br><br>\$0 copay<br>*<br><br>Limited to 2 hearing aid(s) every year                                                          |
| 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>Dental Services</b><br><br>Medicare-covered | <br><br>\$50 copay for each Medicare-covered service.<br>*                                                                                                                                | <br><br>\$15 copay for each Medicare-covered service.<br>*                                                                                                                                |
| Routine Diagnostic and Preventive Services     | \$0 copay<br>*<br><br>Cleanings 2 every year<br>Dental x-rays 1 set(s) every date of service to 3 plan years depending on type of service<br>Oral exams 2 every year                      | \$0 copay<br>*<br><br>Cleanings 2 every year<br>Dental x-rays 1 set(s) every date of service to 3 plan years depending on type of service<br>Oral exams 2 every year                      |
| Fluoride Treatment                             | \$0 copay<br>*<br><br>1 every year                                                                                                                                                        | \$0 copay<br>*<br><br>1 every year                                                                                                                                                        |

## Benefits

|                                  | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                            | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                              |
|----------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Other Diagnostic Dental Services | \$0 copay<br>*<br><br>1 every date of service to 3 plan years depending on type of service | \$0 copay<br>*<br><br>1 every date of service to 3 plan years depending on type of service |
| Other Preventive Dental Services | \$0 copay<br>*<br><br>1 every date of service to 3 plan years depending on type of service | \$0 copay<br>*<br><br>1 every date of service to 3 plan years depending on type of service |
| Routine Comprehensive Services   |                                                                                            |                                                                                            |
| Restorative Services             | <u>Not</u> covered                                                                         | \$0 copay<br>*                                                                             |
| Endodontics/Periodontics         | <u>Not</u> covered                                                                         | \$0 copay<br>*                                                                             |
| Oral/Maxillofacial Surgery       | <u>Not</u> covered                                                                         | \$0 copay<br>*                                                                             |
| Prosthodontics, Fixed            | <u>Not</u> covered                                                                         | \$0 copay<br>*                                                                             |
| Prosthodontics, Removable        | <u>Not</u> covered                                                                         | \$0 copay<br>*                                                                             |
| Adjunctive General Services      | \$0 copay<br>*                                                                             | \$0 copay<br>*                                                                             |

## Benefits

|                                                        | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                      | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                        |
|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        | <b>For more information, limitations and exclusions, please see your Evidence of Coverage. Additional dental limitations and exclusions apply.</b>   | <b>For more information, limitations and exclusions, please see your Evidence of Coverage. Additional dental limitations and exclusions apply.</b>   |
| Additional Dental Information                          | <b>What you should know:</b><br>This plan provides dental services with no annual maximum allowance.                                                 | <b>What you should know:</b><br>This plan includes coverage of routine comprehensive services up to \$2,000 per plan year.                           |
| <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>\$15 copay for all other Medicare-covered eye exams * |
| Routine Eye Exam (Refraction)                          | \$0 copay *<br><br>1 exam(s) every year                                                                                                              | \$0 copay *<br><br>1 exam(s) every year                                                                                                              |
| Glaucoma Screening                                     | \$0 copay for each Medicare-covered service.                                                                                                         | \$0 copay for each Medicare-covered service.                                                                                                         |
| Eyewear<br>Medicare-covered                            | \$0 copay                                                                                                                                            | \$0 copay                                                                                                                                            |

## Benefits

|                                                                                                                      | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                            | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 combined<br>allowance towards contacts<br>and glasses (lenses and/or<br>frames) every year.                                                                                                            | \$0 copay<br>*<br><br>Up to a \$300 combined<br>allowance towards contacts<br>and glasses (lenses and/or<br>frames) every year.                                                                                                            |
| <b>Mental Health Services</b><br><br>Inpatient Visit                                                                 | For each admission, you pay: <ul style="list-style-type: none"> <li>• \$370 copay per day for days 1 through 5</li> <li>• \$0 copay per day for days 6 through 90</li> </ul> *                                                             | For each admission, you pay: <ul style="list-style-type: none"> <li>• \$250 copay per day for days 1 through 5</li> <li>• \$0 copay per day for days 6 through 90</li> </ul> *                                                             |
| Outpatient Individual Therapy Visit                                                                                  | \$40 copay<br>*                                                                                                                                                                                                                            | \$25 copay<br>*                                                                                                                                                                                                                            |
| Outpatient Group Therapy Visit                                                                                       | \$40 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 60</li> <li>• \$0 copay per day for days 61 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 40</li> <li>• \$0 copay per day for days 41 through 100</li> </ul> * |

## Benefits

|                                                                          | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                               | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                 |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| <b>Therapy and Rehabilitation Services</b>                               |                                                                                                                               |                                                                                                                               |
| Physical Therapy                                                         | \$35 copay<br>*                                                                                                               | \$15 copay<br>*                                                                                                               |
| Outpatient Rehabilitation Services Provided by an Occupational Therapist | \$35 copay<br>*                                                                                                               | \$15 copay<br>*                                                                                                               |
| Pulmonary Rehabilitation Services                                        | \$25 copay                                                                                                                    | \$40 copay                                                                                                                    |
| <b>Ambulance</b>                                                         |                                                                                                                               |                                                                                                                               |
| Ground Ambulance                                                         | \$265 copay<br>*                                                                                                              | \$250 copay<br>*                                                                                                              |
| Air Ambulance                                                            | \$265 copay<br>*                                                                                                              | \$250 copay<br>*                                                                                                              |
| <b>Transportation Services (Non-emergency medical transportation)</b>    | <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. |
| Insulin                                                                  | \$35 copay (maximum per month)<br>*                                                                                           | \$35 copay (maximum per month)<br>*                                                                                           |

Benefits

|                 | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000 | Wellcare Simple (HMO)<br>H0174, Plan 010, 000 |
|-----------------|-------------------------------------------------|-----------------------------------------------|
| Allergy Antigen | 0% coinsurance<br>*                             | 0% coinsurance<br>*                           |

| Part D Prescription Drug Coverage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                                                        | Wellcare Simple (HMO)<br>H0174, Plan 010, 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. |
| <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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |
| <b>What You Pay for Insulin:</b><br><b>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.<br><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. |                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        |

| Part D Prescription Drug Coverage                                                          | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000 |                                        | Wellcare Simple (HMO)<br>H0174, Plan 010, 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                               |
| Tier 1<br>(Preferred Generic)                                                              | \$0 / \$0 copay                                 | \$5 / \$15 copay                       | \$0 / \$0 copay                               | \$5 / \$15 copay                       |
| Tier 2<br>(Generic)                                                                        | \$0 / \$0 copay                                 | \$10 / \$30 copay                      | \$0 / \$0 copay                               | \$10 / \$30 copay                      |
| Tier 3<br>(Preferred Brand)                                                                | 25% / 25% coinsurance                           | 25% / 25% coinsurance                  | 25% / 25% coinsurance                         | 25% / 25% coinsurance                  |
| Tier 4<br>(Non-Preferred Drug)                                                             | 46% / 46% coinsurance                           | 46% / 46% coinsurance                  | 35% / 35% coinsurance                         | 36% / 36% coinsurance                  |
| Tier 5<br>(Specialty Tier)<br>Limited to 30 day supply                                     | 25% coinsurance / <u>Not</u> Available          | 25% coinsurance / <u>Not</u> Available | 25% coinsurance / <u>Not</u> Available        | 25% coinsurance / <u>Not</u> Available |
| Tier 6<br>(Select Care Drugs)                                                              | \$0 / \$0 copay                                 | \$0 / \$0 copay                        | \$0 / \$0 copay                               | \$0 / \$0 copay                        |

| Part D Prescription Drug Coverage                                                                                                        | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                |                      | Wellcare Simple (HMO)<br>H0174, Plan 010, 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             |
| Tier 1<br>(Preferred Generic)                                                                                                            | \$0 copay                                                                                                                                                      | \$15 copay           | \$0 copay                                                                                                                                                      | \$15 copay           |
| Tier 2<br>(Generic)                                                                                                                      | \$0 copay                                                                                                                                                      | \$30 copay           | \$0 copay                                                                                                                                                      | \$30 copay           |
| Tier 3<br>(Preferred Brand)                                                                                                              | 25% coinsurance                                                                                                                                                | 25% coinsurance      | 25% coinsurance                                                                                                                                                | 25% coinsurance      |
| Tier 4<br>(Non-Preferred Drug)                                                                                                           | 46% coinsurance                                                                                                                                                | 46% coinsurance      | 35% coinsurance                                                                                                                                                | 36% coinsurance      |
| Tier 5<br>(Specialty Tier)<br>Limited to 30 day supply                                                                                   | <u>Not</u> Available                                                                                                                                           | <u>Not</u> Available | <u>Not</u> Available                                                                                                                                           | <u>Not</u> Available |
| Tier 6<br>(Select Care Drugs)                                                                                                            | \$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. |                      |

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) and Wellcare Simple (HMO) 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 (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                             | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Note:</b> Services with an asterisk (*) may require prior authorization.<br/>Services with a square (■) means a referral may be required.</p> |                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                             |
| <b>Chiropractic Services</b><br>Medicare-covered                                                                                                    | \$15 copay<br>*                                                                                                                                                                                                                             | \$15 copay<br>*                                                                                                                                                                                                                             |
| <b>Acupuncture</b><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>\$15 copay for Medicare-covered Acupuncture received in a Specialist office.<br>* |
| <b>Podiatry Services (Foot Care)</b><br>Medicare-covered                                                                                            | \$50 copay<br>*                                                                                                                                                                                                                             | \$15 copay<br>*                                                                                                                                                                                                                             |

## Additional Benefits

|                                | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Wellcare Simple (HMO)<br>H0174, Plan 010, 000 |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <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> <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>*                                |

## Additional Benefits

|                                                                          | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                               | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Meals</b><br><br>Post-Acute Meals                                     | <u>Not</u> covered                                                                                            | \$0 copay<br>■<br><br><b>What you should know:</b><br>If you qualify, you pay nothing for home delivered meals up to 45 days following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days with a maximum of 42 meals per occurrence for an unlimited number of occurrences per year. |
| <b>Medical Equipment/Supplies</b><br><br>Durable Medical Equipment (DME) | 20% coinsurance<br>*                                                                                          | 20% coinsurance<br>*                                                                                                                                                                                                                                                                                                                |
| Prosthetics                                                              | 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.                                                                                                                                                                                                                       |
| Diabetic Therapeutic Shoes Or Inserts                                    | 20% coinsurance<br>*                                                                                          | 20% coinsurance<br>*                                                                                                                                                                                                                                                                                                                |

## Additional Benefits

|                                                              | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Opioid Treatment Program Services</b>                     | \$50 copay<br>*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$15 copay<br>*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <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.</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.</p> |
| 24-Hour Nurse Advice Line                                    | \$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.                                                                                                                                                                                                                                                                                                                                                                   |

## Additional Benefits

|                      | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000                                                                                                                                                                                | Wellcare Simple (HMO)<br>H0174, Plan 010, 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Wellcare Spendables® | <u>Not</u> covered                                                                                                                                                                                                             | <p>You will receive <b>\$30 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></p> <p>Your card allowance can be used towards:<br/> <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> |
| 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</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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

Additional Benefits

|  | Wellcare Giveback (HMO)<br>H0174, Plan 019, 000  | Wellcare Simple (HMO)<br>H0174, Plan 010, 000               |
|--|--------------------------------------------------|-------------------------------------------------------------|
|  | a Debit card. Debit card restrictions may apply. | Rewards will be loaded onto your Wellcare Spendables® card. |

## 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).

Tiếng Việt LƯU Ý: Chúng tôi có cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí. Các dịch vụ và trợ giúp bổ trợ phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi 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)。

العربية انتباه: تتوفر لك خدمات مساعدة لغوية مجانية. تتوفر كذلك مجانًا مساعدات وخدمات إضافية ملائمة لتزويد المعلومات بتنسيقات قابلة للوصول إليها. اتصل على الرقم 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.

Yorùbá ÀKÍYÈSÍ: Àwọn isẹ̀ ìrànńlọ̀wọ̀ tí èdè wà nílẹ̀ fún ọ̀ lófẹ̀ẹ̀. Àwọn isẹ̀ àtí àwọn ìrànńwọ̀ arannílọ̀wọ̀ tóyẹ̀ láti pèsè ìwífúnni ní àwọn ọ̀nà kíkọ̀sílẹ̀ tóşéé ráàyè sí tún wà nílẹ̀ bákan náà lófẹ̀ẹ̀ 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'akwughị ụgwọ. Kpọọ 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).

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۔

Français REMARQUE : des services d'assistance linguistique gratuits sont à votre disposition. Des services et aides pour obtenir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-374-4056 (TTY : 711).

Français cadien COMMUNIQUE: Des services d'aide linguistique sans frais sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations en formats accessibles sont également proposés sans frais. Composez le 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) నంబర్ కి కాల్ చేయండి.

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.

Deutsch ACHTUNG: Sprachdienstleistungen stehen Ihnen kostenlos zur Verfügung. Geeignete zusätzliche Unterstützung und Dienstleistungen für Informationen in zugänglichen Formaten stehen Ihnen ebenfalls kostenlos zur Verfügung. Rufen Sie folgende Nummer an: 1-877-374-4056 (TTY: 711).

नेपाली ध्यान दिनुहोस्: तपाईंका लागि भाषासम्बन्धी सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन्। सुलभ फर्म्याटहरूमा जानकारी प्रदान गर्नका निम्ति उचित सहायक सामग्री र सेवाहरू पनि निःशुल्क रूपमा उपलब्ध छन्। 1-877-374-4056 (TTY: 711) मा कल गर्नुहोस्।

तुमच्यासाठी विनामूल्य भाषा सहाय्य सेवा उपलब्ध आहेत. सुलभ स्वरूपात माहिती प्रदान करण्यासाठी योग्य अतिरिक्त मदत आणि सेवादेखील विनामूल्य उपलब्ध आहेत. 1-877-374-4056 (TTY: 711) वर कॉल करा.

മലയാളം ശ്രദ്ധിക്കൂ: നിങ്ങൾക്ക് സൗജന്യ ഭാഷാ സഹായ സേവനങ്ങൾ ലഭ്യമാണ്. ആക്സസ് ചെയ്യാവുന്ന ഫോർമാറ്റുകളിൽ വിവരങ്ങൾ നൽകുന്നതിന്, സൗജന്യമായി അനുയോജ്യമായ ഓക്സിഡിയറി സഹായങ്ങളും സേവനങ്ങളും ലഭ്യമാണ്. 1-877-374-4056 (TTY: 711) എന്ന നമ്പറിൽ വിളിക്കുക.

ಕನ್ನಡ ನಿಮ್ಮ ಗಮನಕ್ಕೆ: ನಿಮಗೆ ಉಚಿತ ಭಾಷಾ ಸಹಾಯ ಸೇವೆಗಳು ಲಭ್ಯವಿದೆ. ಪ್ರವೇಶಿಸಬಹುದಾದ ಸ್ವರೂಪಗಳಲ್ಲಿ ಮಾಹಿತಿಯನ್ನು ಒದಗಿಸಲು ಸೂಕ್ತವಾದ ಸಹಾಯಕ ಸಾಧನಗಳು ಮತ್ತು ಸೇವೆಗಳು ಸಹ ಉಚಿತವಾಗಿ ಲಭ್ಯವಿದೆ. ಕರೆ ಮಾಡಿ 1-877-374-4056 (TTY: 711).

தமிழ் உங்களின் கவனத்திற்கு: உங்களுக்கு மொழி உதவிக்கான இலவச சேவைகள் கிடைக்கின்றன. பயன்படுத்தக்கூடிய வடிவங்களில் தகவல்களை வழங்குவதற்குப் பொருத்தமான புலன் உணர்வுக் கருவிகளும் சேவைகளும் இலவசமாகக் கிடைக்கின்றன. 1-877-374-4056 (TTY: 711) என்ற எண்ணை அழைத்திடுங்கள்.

## 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

- ☐ 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.
- ☐ 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).

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.

Wellcare (HMO, HMO SNP, and PPO) includes products that are underwritten by WellCare of Texas, Inc., WellCare National Health Insurance Company, Superior HealthPlan, Inc., and SelectCare of Texas, Inc.

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.

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## 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)