January 1 - December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of WellCare Patriot (HMO-POS)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

This plan, WellCare Patriot (HMO-POS), is offered by WellCare of Georgia, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means WellCare of Georgia, Inc. When it says "plan" or "our plan," it means WellCare Patriot (HMO-POS).)

This document is available for free in Spanish and/or Korean.

Please contact our Customer Service number at 1-866-892-8340 for additional information. (TTY/TDD users should call 711.) Hours are Monday–Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m.

This booklet is also available in different formats, including audio compact disc (CD), braille, and large print. Please call Customer Service if you need plan information in another format (phone numbers are printed on the back cover of this booklet).

Benefits and/or co-payments/coinsurance may change on January 1, 2022.

The provider network may change at any time. You will receive notice when necessary.

Multi-Language Insert
Multi-Language Interpreter Services

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

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

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

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

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

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

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-374-4056** (TTY: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-374-4056** (مكبلاو مصلا فتاه: **711**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-374-4056** (TTY: **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-374-4056** (ATS: **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-374-4056** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-374-4056** (TTY: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-374-4056** (TTY: **711**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer **1-877-374-4056** (TTY: **711**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-374-4056** (TTY: **711**) まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. ب **1-877-374-4056** (TTY: **711**) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-374-4056** (TTY: **711**) पर कॉल करें।

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ. Զանգահարեք **1-877-374-4056** (TTY (հեռատիպ): **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-374-4056** (TTY: **711**).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-374-4056** (TTY: **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-877-374-4056** (TTY: **711**).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-877-374-4056** (TTY: **711**)។

ਧਿਆਨ ਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਾਂਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-877-374-4056** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-877-374-4056 (TTY: **711**)।

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט **1-877-374-4056** .(TTY: **711**)

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-877-374-4056** (መስማት ለተሳናቸው: **711**).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-374-4056** (TTY: **711**).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-374-4056** (TTY: **711**).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti **1-877-374-4056** (TTY: **711**).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-877-374-4056** (TTY: **711**).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-877-374-4056** (TTY: **711**).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-374-4056** (TTY - Telefon za osobe sa ošteĐenim govorom ili sluhom: **711**).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-877-374-4056** (телетайп: **711**).

ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-877-374-4056** (टिटिवाइ: **711**) ।

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel **1-877-374-4056** (TTY: **711**).

ပက်သူဉ်ပက်သး-နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိ**1-877-374-4056** (TTY: **711**)ဒ်

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai **1-877-374-4056** (TTY: **711**).

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaaḷọk **1-877-374-4056** (TTY: **711**).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-877-374-4056** (TTY: **711**).

MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-877-374-4056** (TTY: **711**).

FAKATOKANGA'I: Kapau ‘oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta'etotongi, pea teke lava ‘o ma'u ia. Telefoni mai **1-877-374-4056** (TTY: **711**).

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-877-374-4056** (TTY: **711**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-374-4056** (TTY: **711**).

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu **1-877-374-4056** (TTY: **711**).

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi **1-877-374-4056** (TTY: **711**).

DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. **1-877-374-4056** (TTY: **711**) irtibat numaralarını arayın.

ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە**1-877-374-4056** (TTY: **711**) بکە.

శర్దధ్ పాటట్ండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతునన్టల్యితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిసాత్యి. **1-877-374-4056** (TTY: **711**) కు కాల్ చేయండి.

PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atö kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë **1-877-374-4056** (TTY: **711**).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring **1-877-374-4056** (TTY: **711**).

ATENCIÓ: Si parleu Català, teniu disponible un servei d"ajuda lingüística sense cap càrrec. Truqueu al **1-877-374-4056** (TTY o teletip: **711**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-374-4056** (TTY: **711**).

IGE NTI: O buru na asu Ibo asusu, enyemaka diri gi site na call **1-877-374-4056** (TTY: **711**).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-877-374-4056** (TTY: **711**).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie Lokaiahn Pohnpei komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Nelpon **1-877-374-4056** (TTY: **711**).

Wann du Deitsch (Pennsylvania German/Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff **1-877-374-4056** (TTY: **711**).

E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo hoʻokomo ʻōlelo, loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā **1-877-374-4056** (TTY: **711**).

MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu **1-877-374-4056** (TTY: **711**).

Hagsesda: iyuhno hyiwoniha tsalagi gawonihisdi. Call **1-877-374-4056** (TTY: **711**).

ATENSIÓN: Yanggen un tungó I linguahén Chamoru, i setbision linguahé gaige para hagu dibatde ha . Agang I **1-877-374-4056** (TTY: **711**).

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܡܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝܬ ܕܩܒܠܬ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ **1-877-374-4056** (TTY: **711**).

သတိပြုရန် : အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် **1-877-374-4056** (TTY: **711**) သို့ ခေါ်ဆိုပါ။

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-877-374-4056** (TTY: **711**).

Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-877-374-4056** (TTY: **711**).

ANOMPA PA PISAH: Chahta makilla ish anompoli hokma, kvna hosh Nahollo Anompa ya pipilla hosh chi tosholahinla. Atoko, hattak yvmma im anompoli chi bvnnakmvt, holhtina pa payah **1-877-374-4056** (TTY: **711**).

2021 Evidence of Coverage
Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in WellCare Patriot (HMO-POS), which is a Medicare HMO Point-of-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, WellCare Patriot (HMO-POS).

There are different types of Medicare health plans. WellCare Patriot (HMO-POS) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.) WellCare Patriot (HMO-POS) does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of WellCare Patriot (HMO-POS).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in WellCare Patriot (HMO-POS) between January 1, 2021 and December 31, 2021.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of WellCare Patriot (HMO-POS) after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies.)
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for WellCare Patriot (HMO-POS)

Although Medicare is a Federal program, WellCare Patriot (HMO-POS) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Georgia: Baldwin, Barrow, Bartow, Bibb, Bleckley, Brantley, Bryan, Burke, Butts, Camden, Carroll, Chatham, Chattahoochee, Cherokee, Clarke, Clayton, Cobb, Columbia, Coweta, Crawford, DeKalb, Dodge, Dooly, Douglas, Emanuel, Fayette, Forsyth, Fulton, Glascock, Glynn, Greene, Gwinnett, Haralson, Harris, Heard, Henry, Houston, Jasper, Jefferson, Jenkins, Johnson, Jones, Lamar, Liberty, Lincoln, Long, Macon, Marion, McDuffie, McIntosh, Meriwether, Monroe, Morgan, Muscogee, Newton, Oconee, Paulding, Peach, Pickens, Pike, Polk, Pulaski, Putnam, Richmond, Rockdale, Screven, Spalding, Stewart, Talbot, Treutlen, Troup, Twiggs, Upson, Walton, Warren, Washington, Wayne, Wheeler, Wilkes, Wilkinson.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet.) When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

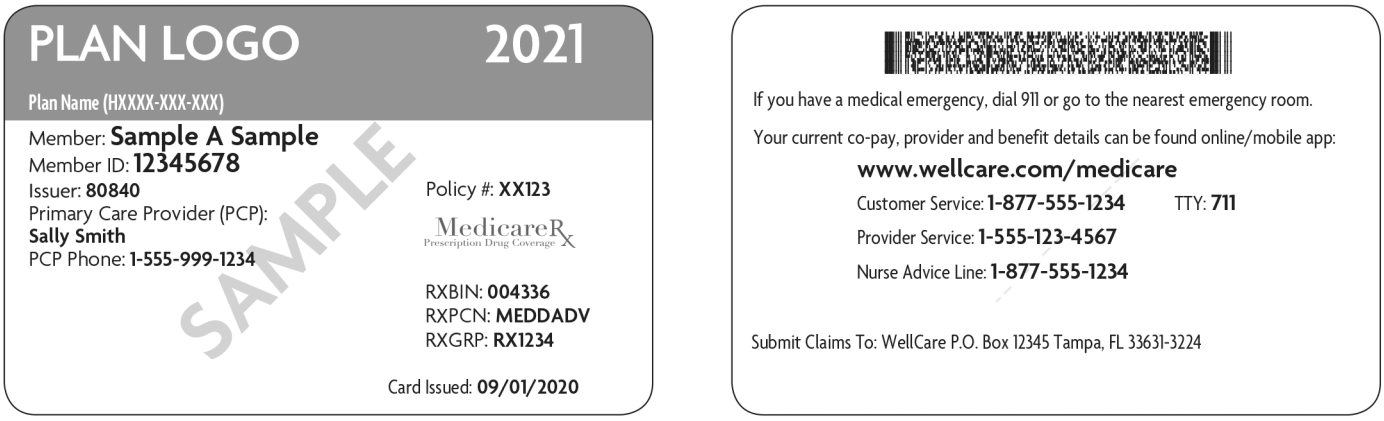
Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify WellCare Patriot (HMO-POS) if you are not eligible to remain a member on this basis. WellCare Patriot (HMO-POS) must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card - Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your WellCare Patriot (HMO-POS) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your WellCare Patriot (HMO-POS) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

The *Provider Directory* lists our network providers and durable medical equipment suppliers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.wellcare.com/FAP.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. A Medical Group is an association of physicians, including PCPs and specialists, and other health care providers, including hospitals, that contract with the plan to provide services to enrollees. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

Your plan has a Point-of-Service (POS) option. The POS option is an additional benefit that covers certain medically necessary services you may get from out-of-network providers. When you use your POS (out-of-network) benefit you are responsible for more of the cost of care except in an emergency. Except in an emergency, always talk to your Primary Care Physician (PCP) before seeking care from an out-of-network provider. Your PCP will notify us by requesting approval from the plan ("prior authorization"). See Chapter 3 (*Using the plan's coverage for your medical services*) for more information.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Service (phone numbers for Customer Service are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at *www.wellcare.com/FAP*, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for WellCare Patriot (HMO-POS)

Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for WellCare Patriot (HMO-POS). You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2021* gives information about these premiums in the section called "2021 Medicare Costs." This explains how the Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2021* from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users, call 1-877-486-2048.

Section 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider (PCP) or Independent Practice Association (IPA).

An IPA (Independent Practice Association) is an association of physicians, including PCPs, specialists, and other health care providers, including hospitals, that is contracted with the plan to provide services to members.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet). In some cases, we may need to call you to verify the information we have on file.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.

- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 WellCare Patriot (HMO-POS) contacts
(how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to WellCare Patriot (HMO-POS) Customer Service. We will be happy to help you.

Method	Customer Service - Contact Information
CALL	1-866-892-8340 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
FAX	1-877-297-3112
WRITE	WellCare Health Plans Customer Service, PO Box 31370 Tampa, FL 33631
WEBSITE	www.wellcare.com/medicare

How to contact us when you are asking for a coverage decision about your medical care

A "coverage decision" is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care - Contact Information
CALL	1-866-892-8340 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
FAX	1-813-262-2802
WRITE	WellCare Health Plans Coverage Determinations Department - Medical P.O. Box 31370 Tampa, FL 33631-3370

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Appeals for Medical Care - Contact Information
CALL	1-866-892-8340 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
FAX	1-866-388-1769
WRITE	WellCare Health Plans Appeals Department - Medical P.O. Box 31368 Tampa, FL 33631-3368

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Complaints about Medical Care - Contact Information
CALL	1-866-892-8340 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
FAX	1-866-388-1769
WRITE	WellCare Health Plans Grievance Department P.O. Box 31384 Tampa, FL 33631-3384
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx

Where to send a request asking us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests - Contact Information
WRITE	WellCare Health Plans Medical Reimbursement Department P.O. Box 31370 Tampa, FL 33631
WEBSITE	www.wellcare.com/medicare

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare - Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

WEBSITE www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provides Medicare eligibility status information.
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about WellCare Patriot (HMO-POS):

- **Tell Medicare about your complaint:** You can submit a complaint about WellCare Patriot (HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaint seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program
(free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Georgia, the SHIP is called GeorgiaCares.

GeorgiaCares is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

GeorgiaCares counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. GeorgiaCares counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	GeorgiaCares (Georgia SHIP) - Contact Information
CALL	1-866-552-4464
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	2 Peachtree Street, NW, 33rd Floor Atlanta, GA 30303
WEBSITE	http://www.mygeorgiacares.org

SECTION 4 Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Georgia, the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (Georgia's Quality Improvement Organization) - Contact Information
CALL	1-888-317-0751 Weekdays: 9:00 a.m. to 5:00 p.m. Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time Weekends and Holidays: 11:00 a.m. to 3:00 p.m. Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time
TTY	1-855-843-4776 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	www.keproqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security - Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and co-payments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Georgia Department of Community Health.

Method	Georgia Department of Community Health - Contact Information
CALL	1-404-656-4507 Monday - Friday 8 am - 5 pm EST
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	2 Peachtree Street NW Atlanta, GA 30303
WEBSITE	http://dch.georgia.gov

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board - Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are four exceptions:*
  - The plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Contact the plan or your PCP prior to seeking out-of-network care, as authorization may be required. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
  - The Point-of-Service (POS) benefit allows you to access other services from non-network providers. You will pay more to access services outside the network when you use your POS benefit. For more information see Section 2.4 of this chapter.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

When you become a member of our plan, you must choose a plan provider to be your primary care provider (PCP). Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. Primary Care Providers are generally Family/General Practice, Geriatrics and Internal Medicine providers.

By accepting coverage, you authorize us and all health service providers to furnish your medical records and information about you to your Primary Care Provider. Enrolling in our plan does not guarantee that covered services will be provided by a particular Primary Care Provider, network provider or hospital or other provider on the list of network providers. When a provider no longer has a contract with us or is not currently accepting new plan members, you must choose among remaining network providers. We will provide you with periodic updates (or anytime at your request) regarding the network status of providers, but it is suggested that you verify the network status of a provider, hospital or other provider by calling Customer Service (phone numbers are printed on the back cover of this booklet). If necessary, Customer Service can provide assistance in referring you to providers in our network.

Within 90 days of the effective date of your enrollment, we will contact you to conduct a health status survey. This is particularly important if you have complex or serious medical conditions. We have approved procedures to identify, assess, and establish treatment plans for Members with complex or serious medical conditions. In addition, we maintain procedures to ensure that Members are informed of healthcare needs that require follow-up and receive training in self-care and other measures to promote their own health.

If your Primary Care Provider's contract with us is terminated (by us or by the Primary Care Provider), we will make every effort to notify you at least 30 calendar days prior to the effective date of the termination. For other network providers, you will be notified of the termination if you see that provider on a regular basis. Contact Customer Service (phone numbers are printed on the back cover of this booklet) for assistance in selecting another provider.

Should you require hospitalization, your care while hospitalized will be coordinated by your Primary Care Provider or a network admitting Provider. This Provider will follow your Hospital Confinement and will inform you of your condition or progress. If this Provider is not your Primary Care Provider, he or she may also communicate with your Primary Care Provider. Your PCP will provide most of your care and will help you

arrange or coordinate the rest of the covered services you get as a Member of our Plan. This includes but is not limited to:

- X-rays
- Laboratory tests
- Physical, Occupational and/or Speech Therapies
- Care from doctors who are specialists
- Hospital admissions
- Follow-up care
- Mental or Behavioral Health Services
- Care you get from out-of-network providers

“Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Chapter 6 informs you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

You select a PCP by using the *Provider Directory* or by getting help from Customer Service (phone numbers are printed on the back cover of this booklet). Generally, you select a PCP at enrollment and your PCP will be printed on your Member ID card.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network of providers and you would have to find a new PCP.

You may change your PCP at any time by calling Customer Service. Customer Service can assist you in selecting a new Primary Care Provider. You should allow at least 31 days for a change in a Primary Care Provider selection to take effect. Most Primary Care Provider changes will be effective on the first day of the month. In the event that you decide to change your Primary Care Provider to a new Primary Care Provider who also was the attending physician for a recent inpatient stay, the effective date of that Primary Care Provider change will be the first of the month following a ninety (90) day

period after the date you were discharged from the hospital. In order for covered services to be covered under this EOC, you must continue to obtain covered services that are provided, ordered or arranged through your current Primary Care Provider until the change takes effect.

To choose your new PCP, simply call Customer Service and we will help you find a PCP who

- is accepting new patients
- can effectively continue coordinating any specialty care and other health care you were receiving before changing your PCP.

Customer Service will then change your membership record to show the name of your new PCP. If you request to change your PCP on or before the 10th day of the month, the change will be made effective as of the first day of the month in which you call (retroactively). If you call after the 10th day of the month, your PCP change will be effective the first day of the following month. Customer Service will also send you a new membership card that shows the name and phone number of your new PCP.

Members participating in case management may also work with their case manager to complete the above process.

Example: If your PCP request is made on or before January 10, the change can be made effective January 1, 2021. If your request is made on or after January 11 then the change will become effective on February 1.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

Covered services that require a Prior Authorization are listed in the Benefits Chart in Chapter 4, Section 2.1. Covered services requiring Prior Authorization may include, but are not limited to:

a) Diagnostic and therapeutic services;
b) Home Health Agency services;
c) Orthotic and Prosthetic devices; and
d) Durable Medical Equipment, oxygen and medical supplies.

Whenever you have a question or concern regarding the covered service authorization requirements under this Plan, please contact Customer Service.

Before performing certain types of services, your PCP or plan specialist may need to get approval in advance from the plan (prior authorization). If granted, authorization will allow you to receive a specific service (or number of specific services). Once you have received the authorized number of services, your PCP or the specialist will need to get additional approval from the plan for you to continue receiving specialized treatment. See the benefits chart in Chapter 4 Section 2.1 to learn which services may require prior authorization, and always ask your provider to confirm with the plan if you are unsure.

What if a specialist or another network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider to manage your care.

You can call Customer Service (phone numbers are printed on the back cover of this booklet) for assistance with any provider related issue, including finding a new provider.

Section 2.3 How to get care from out-of-network providers

Similar to the referral requirements for care received from network providers (see Chapter 3, section 2.3), you must get a referral from your PCP prior to getting care from out-of-network providers via your POS benefit. If you do not get a referral, you will have to pay the full cost of any services you receive. A referral or prior authorization is never required for emergency care, urgently needed care when network providers are unavailable, and dialysis for members with ESRD who are temporarily out of the service area, and you will always pay your network cost shares in these scenarios.

If an out-of-network provider sends you a bill that you think we should pay, please contact Customer Service or send the bill to us for payment. We will pay your doctor for our share of the bill and your doctor may bill you for the amount you owe, if any. Out of network providers who accept Medicare cannot bill for any more than what is allowed by Original Medicare. It is best to ask an out-of-network provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. (Please note that we cannot pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm that they have not opted out of Medicare.) If we determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. Any services not covered at the in-network benefit level will not be covered at the Point-of-Service (POS) benefit level. See *Chapter 4* for a list of covered services that are included in the POS (out-of-network) benefit and your cost share when you use it.

Keep in mind that the plan negotiates lower rates with network providers and covers more of the costs for covered services that you get from network providers.

Because your plan has a POS option, please be aware of the following:

- You will pay more for services received from out-of-network providers (except for the special circumstances discussed earlier in this section).
- When you use your POS benefit, you are choosing to seek care outside the plan's contracted network. Out-of-network providers may choose not to accept our plan members as patients. If an out-of-network provider refuses to accept our plan, we recommend you seek care from within our contracted network.

- When you use your POS benefit, you pay the POS benefit coinsurance because you are getting the covered item or service from an out-of-network provider. Even though out-of-network providers are not contracted with the plan, they are subject to the laws governing the Original Medicare Program.
- Balance billing is when a provider bills you for the difference between the amount your provider charges, and the amount the plan will pay on your behalf. All providers who accept Medicare are prohibited from balance billing. This includes providers seen via your POS benefit, who may only charge you your POS coinsurance.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You can call Customer Service at the number on the back of this booklet or the number located on the back of your membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where

getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Chapter 4 also provides details about our coverage of emergency care and urgently needed services received while you are traveling outside the United States and its territories.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care — thinking that your health is in serious danger — and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care;
- *- or -* The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be

furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

Please contact your PCP's office 24 hours a day if you need urgent care. You may be directed to obtain urgent care at a network urgent care center. A list of network urgent care centers can be found in the Provider Directory or on our website at www.wellcare.com/medicare. If urgent care services are received in your doctor's office, you will pay the office visit co-payment; however, if urgent care services are received at a network urgent care center or walk-in clinic, you will pay the urgent care center co-payment, which may be different. See Chapter 4. Medical Benefits Chart (what is covered and what you pay) for the co-payment that applies to services provided in a doctor's office or network urgent care center or walk-in clinic.

You may also contact the Nurse Advice Line at any time. A nursing professional is standing by with answers to your questions 24 hours a day, seven days a week. For more information regarding the Nurse Advice Line, see Chapter 4, Health and Wellness Education Programs, or call Customer Service (phone numbers are printed on the back cover of this booklet).

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers worldwide emergency and urgently needed services outside the United States under the following circumstances. For more information about this benefit, see *Chapter 4*.

- You are covered for up to $50,000 when traveling outside the United States under your worldwide emergency and urgent care coverage.

- There is no coverage for medication purchased while outside the United States.
- Visit any hospital while outside the United States in case of an emergency. Emergency room cost-shares are not waived if you are admitted for inpatient hospital care.
- Please contact us within 48 hours, if possible, to advise us of your emergency room visit.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.wellcare.com/disasterrecovery for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medical services that are medically necessary, these services are listed in the plan’s Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren’t covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Costs paid once a benefit limit has been reached will not count toward your out-of-pocket maximum. This is because services provided after a benefit limit has been reached are not covered by the plan. For more information, see Chapter 4, Section 1.2. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our

plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following**:

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care

services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 Receiving Care From a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care;
  - - *and* - You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Your stay in a religious non-medical health care institution is not covered by our plan unless you obtain authorization (approval) in advance from our plan and will be subject to the same coverage limitations as the inpatient or skilled nursing facility care you would otherwise have received. Please refer to the benefits chart in Chapter 4 for coverage rules and additional information on cost-sharing and limitations for inpatient hospital and skilled nursing coverage.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying co-payments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, WellCare Patriot (HMO-POS) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave WellCare Patriot (HMO-POS) or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is 20% of the cost (In-Network) or 20% of the cost (Out-of-Network/Point-of-Service (POS)) every 36 months.

If prior to enrolling in WellCare Patriot (HMO-POS) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in WellCare Patriot (HMO-POS) is 20% of the cost (In-Network) or 20% of the cost (Out-of-Network/Point-of-Service (POS)).

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining WellCare Patriot (HMO-POS), join WellCare Patriot (HMO-POS) for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in WellCare Patriot (HMO-POS) and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

For 2021, our plan will cover COVID-19 testing for a $0 co-payment. This service will be covered even without an official declaration of a public health emergency for the entire plan year.

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2021 is $3,400. The amounts you pay for copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $3,400, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

- If you believe a provider has “balance billed” you, call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021* Handbook. View it online at www.medicare.gov or ask for 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.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered screening ultrasound for abdominal aortic aneurysm preventive screenings. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain ***Prior Authorization (approval in advance) may be required*** Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: ● Lasting 12 weeks or longer; ● nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); ● not associated with surgery; and ● not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	**In-Network:** $0 co-payment for Medicare-covered acupuncture for chronic low back pain services in a primary care office. $0 co-payment for Medicare-covered acupuncture for chronic low back pain services in a specialist office. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered acupuncture for chronic low back pain services in a primary care office. 20% of the cost for Medicare-covered acupuncture for chronic low back pain services in a specialist office.
Ambulance services ***Prior Authorization (approval in advance) may be required*** ● Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the	**In-Network:** $200 co-payment for Medicare-covered ambulance services per one-way trip.

Services that are covered for you	What you must pay when you get these services
Ambulance services (continued)	
nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. ● Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered ambulance services per one-way trip. The cost share is not waived if you are admitted for Inpatient hospital care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for this preventive service. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered

Services that are covered for you	What you must pay when you get these services
Annual wellness visit (continued)	during that visit.
 **Bone mass measurement** For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered bone mass measurement. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.

Services that are covered for you	What you must pay when you get these services
 **Breast cancer screening (mammograms)** Covered services include: ● One baseline mammogram between the ages of 35 and 39 ● One screening mammogram every 12 months for women age 40 and older ● Clinical breast exams once every 24 months ● One diagnostic mammogram as medically necessary	**In-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. $0 co-payment for Medicare-covered breast exams. $0 co-payment for diagnostic mammograms. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered breast exams. 20% of the cost for diagnostic mammograms. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.

Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services ***Prior Authorization (approval in advance) may be required*** Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-Network:** $35 co-payment for Medicare-covered cardiac rehabilitation services. $35 co-payment for Medicare-covered intensive cardiac rehabilitation services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered cardiac rehabilitation services. 20% of the cost for Medicare-covered intensive cardiac rehabilitation services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) (continued)	
	intensive therapy to reduce the risk of cardiovascular disease. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered cardiovascular disease testing. If your physician performs additional diagnostic or

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease testing (continued)	surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
 **Cervical and vaginal cancer screening** Covered services include: ● For all women: Pap tests and pelvic exams are covered once every 24 months ● If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered preventive Pap and pelvic exams. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening (continued) during that visit.	
Chiropractic services ***Prior Authorization (approval in advance) may be required*** Covered services include: ● We cover only manual manipulation of the spine to correct subluxation.	**In-Network:** $0 co-payment for Medicare-covered chiropractic services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered chiropractor services.
Colorectal cancer screening For people 50 and older, the following are covered: ● Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: ● Guaiac-based fecal occult blood test (gFOBT) ● Fecal immunochemical test (FIT) DNA Based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: ● Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover:	**In-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. $100 co-payment for a screening barium enema. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered colorectal screenings. 20% of the cost for a

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening (continued) ● Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy For diagnostic colonoscopy, see the "Outpatient diagnostic tests and therapeutic services and supplies" section in the Medical Benefits Chart	screening barium enema. During a colonoscopy that is being completed as a preventive screening, abnormal tissue and/or polyp removal will be covered at a $0 co-payment. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Dental services ***Prior Authorization (approval in advance) may be required*** In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: Medicare-covered dental services which may include: ● Services that are an integral part of a covered procedure (e.g., reconstruction of the jaw following accidental injury). ● Extractions done in preparation for radiation	**In-Network:** $0 co-payment for Medicare-covered dental services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered dental services.

Services that are covered for you	What you must pay when you get these services
Dental services (continued) treatment for neoplastic diseases involving the jaw. ● Oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances.	
Our plan also covers the following supplemental (i.e., routine) dental services: ● Preventive services ○ Oral Exam: 1 every 6 months ○ Cleaning: 1 every 6 months ○ Dental X-ray: 1, 2 or 4 per procedure; 1, 2 or 4 every 1 or 3 years depending on the type of X-ray (bitewing, periapical, occlusal, panoramic, complete series, extraoral, sialography, temporomandibular, tomographic, cephalometric, oral/facial or cone beam) ○ Fluoride Treatment: 1 every year ○ Emergency Treatment: 1 every year. In general, any dental problem that requires immediate treatment in order to save a tooth, stop ongoing tissue bleeding or alleviate severe pain is considered a dental emergency. A severe infection or abscess in the mouth can be life-threatening and should be dealt with immediately. If your dentist can't be reached, seek hospital emergency room care. ● Additional comprehensive dental services ○ Diagnostic: 1 every year, per test. For example, pulp vitality test. ○ Restorative: 1 amalgam, resin, or composite	**Supplemental (i.e., routine) dental services:** **In-Network:** $0 co-payment for each supplemental (i.e., routine) dental service covered by the plan.* There is a maximum plan benefit coverage amount of $1,500 per year, which applies to all supplemental (i.e., routine) dental services - both preventive and additional comprehensive - covered by the plan. You are responsible for any cost above the $1,500 maximum.*

Services that are covered for you	What you must pay when you get these services
Dental services (continued) filling per tooth, every 3 years. 1 inlay or onlay per tooth, every 5 years ○ Endodontic: 1 per tooth, per lifetime. For example, root canal. ○ Extraction: 1 removal of erupted or exposed roots per tooth, per lifetime ○ Non-Routine Services: 1 every 6 to 24 months ○ Periodontic: 1 deep cleaning every 2 years, per quadrant, with 1 deep cleaning maintenance every 6 months. 1 treatment of disease processes affecting the gums and bone that support the teeth, per tooth, quadrant, arch, or procedure, every 6 months or 1, 2 or 3 years, or per lifetime. Depending on the service provided; 1 full mouth debridement every 3 years ○ Prosthodontic: For example, 1 complete or partial denture every 5 years. Denture adjustments and repairs every 1, 2, or 5 years, depending on the type of service (add, replace, rebase, or reline). 1 crown per tooth, every 5 years. 1 replacement crown every year, per tooth. ○ Other Oral Maxillofacial Surgery: For example, 1 surgical removal per tooth, per lifetime; 1 closure of an oroantral fistula (an abnormal passageway between your sinus and the roof of your mouth) every 5 years, per procedure ***Limitations and exclusions apply. Before obtaining services, members are advised to discuss their treatment options with a routine dental services participating provider. Treatment must be started and completed while covered by the plan during the***	

Services that are covered for you	What you must pay when you get these services
Dental services (continued) ***plan year. The cost of dental services not covered by the plan is the responsibility of the member.*** Supplemental (i.e., routine) dental services must be received from a participating Medicare provider in order to be covered by the plan.	
 **Depression screening** We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered screening. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.

Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered diabetes screening tests. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Diabetes self-management training, diabetic services and supplies ***Prior Authorization (approval in advance) may be required*** For all people who have diabetes (insulin and non-insulin users). Covered services include: ● Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet	**In-Network:** $0 co-payment for Medicare-covered diabetes self-management training. $0 co-payment for Medicare-covered diabetes monitoring supplies.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies (continued)	
devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. ● For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. ● Diabetes self-management training is covered under certain conditions. One Touch products by Lifescan are our preferred diabetic testing supplies (glucose monitors & test strips). To get more information about the items that are on the preferred diabetic testing supplies list, please contact Customer Service at the number listed on the back of this booklet. If you use diabetic testing supplies that are not preferred by the plan, speak with your doctor to get a new prescription or to request prior authorization for a non-preferred blood glucose monitor and test strips.	20% of the cost for Medicare-covered therapeutic shoes or inserts. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for diabetes self-management training. 20% of the cost for Medicare-covered therapeutic shoes or inserts. 20% of the cost for Medicare-covered diabetes monitoring supplies. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Durable medical equipment (DME) and related supplies	**In-Network:**

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (continued)	
Prior Authorization (approval in advance) may be required (For a definition of "durable medical equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.	20% of the cost for Medicare-covered durable medical equipment. 20% of the cost for Medicare-covered medical supplies. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered durable medical equipment. 20% of the cost for Medicare-covered medical supplies.
Emergency care Emergency care refers to services that are: ● Furnished by a provider qualified to furnish emergency services, and ● Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.	$120 co-payment for Medicare-covered emergency room visits. If you are admitted to the hospital within 24 hours for the same condition, the co-payment is waived for the emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network

Services that are covered for you	What you must pay when you get these services
Emergency care (continued)	
Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Currently, Medicare and Medicare Advantage programs do not recognize Freestanding Emergency Departments (FSED), which are distinct and separate from hospitals, as providers qualified to furnish emergency services. Services received at freestanding ERDs will not be covered by our plan (HMO) and will be the financial responsibility of the member.	hospital in order for your care to continue to be covered *OR* you must have your inpatient care at the out-of-network hospital authorized by the plan, and your cost is the cost sharing you would pay at a network hospital.
Outside the United States - Worldwide Emergency Coverage Emergency Room or urgent care visits outside the United States are covered.	**Outside the United States – Worldwide Emergency Coverage:** $120 co-payment for emergency services outside of the U.S. You are covered for up to $50,000 every year for emergency or urgent care services outside the United States.* The worldwide emergency room cost-share is not waived if you are admitted for inpatient hospital care.
Flex Card ***Prior Authorization (approval in advance) may be required*** The Flex Card benefit is a debit card that may be used to reduce up to $1,000 of your out of pocket expenses at	There is no coinsurance, co-payment, or deductible for Flex Card.

Services that are covered for you	What you must pay when you get these services
Flex Card (continued) a dental, vision or hearing provider. The card may be used to reduce out of pocket expenses associated with the dental, vision and hearing benefits described in the dental, vision and hearing sections listed within this chart. The debit card is prepaid by the plan; it is not a credit card. You cannot convert the card to cash or loan it to other people. Cosmetic procedures are not covered under this benefit. Any unused allocated money will revert to the plan at the end of the year or when you leave the plan. A reimbursement is available for dental, vision, and hearing services received from providers that do not accept debit cards or in the event of a card failure. You must submit a claim form for reimbursement along with the original printed, itemized receipt from the provider location. Claims must be submitted within 90 days of the date of purchase on your receipt. To request a claim form, contact Customer Service at the number printed on the back cover of this booklet.	
Health and wellness education programs ***Prior Authorization (approval in advance) may be required***	
Annual Physical Exam Annual physical exam includes examination of the heart, lung, abdominal and neurological systems, as well as a hands-on examination of the body (such as head, neck and extremities) and detailed medical/family history, in addition to services included in the Annual Wellness Visit.	**In-Network:** $0 co-payment for an annual physical exam. **Out-of-Network/Point-of-Service (POS):** $0 co-payment for an annual physical exam.
Fitness Membership	$0 co-payment for a

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs (continued)	
SilverSneakers® Fitness Membership Annual membership at a participating fitness center, or for members who do not live near a SilverSneakers participating fitness center, and prefer to exercise at home, see SilverSneakers Steps option below. SilverSneakers Steps members can choose from available exercise programs to be shipped to them at no cost. A Fitbit fitness tracker is included in the home kit. For more information regarding the fitness benefit, please call Customer Service (phone numbers are printed on the back cover of this booklet).	fitness membership.
Nurse Advice Line Members may call when they have questions about symptoms they feel, whether they should see a doctor or go to a hospital or other health-related issues. A nursing professional is standing by with answers 24 hours a day, seven days a week. For more information regarding the Nurse advice line, please call Customer Service (phone numbers are printed on the back cover of this booklet).	$0 co-payment for the Nurse Advice Line.
Personal Emergency Response System (PERS) - Medical Alert System Members can choose a traditional "hard-wired" PERS that is connected via a landline, or select a cellular (wireless) system. For hard-wired systems, an existing landline phone is required. Call Customer Service at the number listed on the back of this booklet to find out more information.	$0 co-payment for Personal Emergency Response System (PERS) – Medical Alert System.
Hearing services ***Prior Authorization (approval in advance) may be***	**In-Network:** $0 co-payment for each

Services that are covered for you	What you must pay when you get these services
Hearing services (continued)	
required Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Our plan also covers the following supplemental (i.e., routine) hearing services: ● 1 routine hearing exam every year. ● 1 hearing aid fitting and evaluation every year. ● A maximum of $2,000 towards the cost of 2 non-implantable hearing aid(s) every year. Benefit includes a 1-year standard warranty and 1 package of batteries. Note: Any cost above $1,000 per hearing aid is the member's responsibility and additional hearing aids are not covered. Routine hearing services must be received from a participating provider in order to be covered by the plan.	Medicare-covered diagnostic hearing exam. **Out-of-Network/Point-of - Service (POS):** 20% of the cost for each Medicare-covered diagnostic hearing exam. **Supplemental (i.e., routine) hearing services:** **In-Network:** $0 co-payment for 1 routine hearing exam every year.* $0 co-payment for 1 hearing aid fitting and evaluation every year.* $0 co-payment for 2 hearing aid(s) every year.*
Help with Certain Chronic Conditions **In-home support services** ***Prior Authorization (approval in advance) may be required.***	**In-Network:** $0 co-payment for each in-home support services visit for up to 24 visits every year.

Services that are covered for you	What you must pay when you get these services
Help with Certain Chronic Conditions (continued) If you meet certain clinical criteria, we offer access to in-home support services, including cleaning, household chores and meal preparation. Services must be recommended or requested by a licensed plan clinician or a licensed plan provider. You may participate in care management or be assessed by a care manager. Documentation of one of the following is required for services: ● Alzheimer's/other dementia diagnosis ● joint replacement surgery ● fall recovery ● limb amputation ● cataract/retinal/other eye surgery ● advanced cardio pulmonary disease ● stroke ● ambulation with assist device ● impaired vision ● frequent hospitalizations ● frequent ER visits ● post-surgery with chronic diseases, including one of the following: diabetes, COPD, congestive heart failure (CHF), urinary tract infection (UTI), renal disease, cancer, or behavioral health diagnosis. Services will be provided in 2-hour increments.	

Services that are covered for you	What you must pay when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: ● One screening exam every 12 months For women who are pregnant, we cover: ● Up to three screening exams during a pregnancy	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered preventive HIV screening. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Home health agency care ***Prior Authorization (approval in advance) may be required*** Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.	**In-Network:** $0 co-payment for Medicare-covered skilled nursing and home health aide services. 20% of the cost for Medicare-covered medical equipment.

Services that are covered for you	What you must pay when you get these services
Home health agency care (continued) Covered services include, but are not limited to: ● Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) ● Physical therapy, occupational therapy, and speech therapy ● Medical and social services ● Medical equipment and supplies	**Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered skilled nursing and home health aide services. 20% of the cost for Medicare-covered medical equipment. There may also be a co-payment and/or coinsurance for Medically Necessary Medicare-covered services for Durable Medical Equipment, prosthetic devices, certain medical supplies, and Medicare Part B prescription drugs, where applicable.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump,) and supplies (for example, tubing and catheters). Covered services include, but are not limited to: ● Professional services, including nursing services,	**In-Network:** $0 co-payment for professional services from a Primary Care Provider (PCP), including nursing services, training and education, remote monitoring and monitoring services. $0 co-payment for

Services that are covered for you	What you must pay when you get these services
Home infusion therapy (continued) furnished in accordance with the plan of care ● Patient training and education not otherwise covered under the durable medical equipment benefit ● Remote monitoring ● Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	professional services from a specialist, including nursing services, training and education, remote monitoring and monitoring services. Home infusion equipment and supplies are covered under your Durable Medical Equipment (DME) benefit. Please see the "Durable medical equipment (DME) and related supplies" section for cost-sharing information. Home infusion drugs are covered under your Medicare Part B Prescription Drugs benefit. Please see the "Medicare Part B Prescription Drugs" section for cost-sharing information. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for professional services from a Primary Care Provider (PCP), including nursing services, training and education, remote

Services that are covered for you	What you must pay when you get these services
Home infusion therapy (continued)	
	monitoring and monitoring services. 20% of the cost for professional services from a specialist, including nursing services, training and education, remote monitoring and monitoring services. Home infusion equipment and supplies are covered under your Durable Medical Equipment (DME) benefit. Please see the "Durable medical equipment (DME) and related supplies" section for cost-sharing information. Home infusion drugs are covered under your Medicare Part B Prescription Drugs benefit. Please see the "Medicare Part B Prescription Drugs" section for cost-sharing information.

Services that are covered for you	**What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: ● Drugs for symptom control and pain relief ● Short-term respite care ● Home care For Hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: ● If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. ● If you obtain the covered services from an	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. See "Physician/Practitioner services, including doctor's office visits" section for cost sharing amounts for hospice consultation services.

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) <u>For services that are covered by our plan but are not covered by Medicare Part A or B</u>: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: ● Pneumonia vaccine ● Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary ● Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B ● Other vaccines if you are at risk and they meet Medicare Part B coverage rules	**In-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. 20% of the cost for other Medicare Part B-covered vaccines. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for the

Services that are covered for you	What you must pay when you get these services
Immunizations (continued)	
	pneumonia, influenza, and Hepatitis B vaccines. 20% of the cost for other Medicare Part B-covered vaccines. We offer all flu vaccines to our members at no cost. You can receive your flu vaccine from your doctor, at many local pharmacies and clinics, or you can call the Customer Service number on the back of your member ID card to find a flu shot provider near you. A vaccine and/or immunization must be considered a Part B drug by Medicare in order to be covered under this benefit. Some vaccinations and their administration, such as the Shingles vaccination, are considered Part D Drugs and are not covered under this benefit. If your physician performs additional diagnostic or surgical procedures or if other medical services are

Services that are covered for you	What you must pay when you get these services
Immunizations (continued)	provided for other medical conditions in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Inpatient hospital care ***Prior Authorization (approval in advance) may be required*** Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. You are covered for days 1-90 per admission. Covered services include, but are not limited to: ● Semi-private room (or a private room if medically necessary) ● Meals including special diets ● Regular nursing services ● Costs of special care units (such as intensive care or coronary care units) ● Drugs and medications ● Lab tests ● X-rays and other radiology services ● Necessary surgical and medical supplies ● Use of appliances, such as wheelchairs ● Operating and recovery room costs	**In-Network:** For each Medicare-covered hospital stay: $325 co-pay per day for days 1-5 and a $0 co-pay per day for days 6-90. No additional hospital days per admission. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered hospital stay. No additional hospital days per admission. Except in an emergency, your doctor must tell the plan in advance that you are going to be admitted to the hospital. If you get

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) ● Physical, occupational, and speech language therapy ● Inpatient substance abuse services ● Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Transportation and lodging reimbursement requires a minimum of 60 miles one-way to transplant center and is limited to $10,000 total per transplant, regardless of total miles traveled and duration of treatment. ● Blood - including storage and administration. Coverage of whole blood and packed red cells are covered beginning with the first pint used ● Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the	authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. Lifetime Reserve Days: $0 co-payment per day. Lifetime Reserve Days are additional days that the plan will pay for when members are in a hospital for more than the number of days covered by the plan. Members have a total of 60 reserve days that can be used during their lifetime. Medicare hospital benefit periods do not apply. For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility (such as Acute Inpatient Rehabilitation Hospital or to another Acute care Hospital) is considered a new admission. Cost shares are applied

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued)	
hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	starting on the first day of admission and do not include the date of discharge.
Inpatient mental health care ***Prior Authorization (approval in advance) may be required*** ● Covered services include mental health care services that require a hospital stay. You receive up to 190-days in a psychiatric hospital in a lifetime. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. Except in an emergency, your doctor must tell the plan in advance that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.	**In-Network:** For each Medicare-covered hospital stay: $325 co-pay per day for days 1-4 and a $0 co-pay per day for days 5-90. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered hospital stay. Medicare hospital benefit periods do not apply. For

Services that are covered for you	What you must pay when you get these services
Inpatient mental health care (continued)	
	inpatient mental health care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility (such as Acute Inpatient Rehabilitation Hospital or to another Acute care Hospital) is considered a new admission. Cost shares are applied starting on the first day of admission and do not include the date of discharge. Lifetime Reserve Days: $0 co-payment per day. Lifetime Reserve Days are additional days that the plan will pay for when members are in a hospital for more than 90 days. Members have a total of 60 reserve days that can be used during their lifetime.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay ***Prior Authorization (approval in advance) may be***	If you have exceeded the maximum number of inpatient days covered by the plan, the plan will not

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)	
required If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: ● Physician services ● Diagnostic tests (like lab tests) ● X-ray, radium, and isotope therapy including technician materials and services ● Surgical dressings ● Splints, casts and other devices used to reduce fractures and dislocations ● Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices ● Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition ● Physical therapy, speech therapy, and occupational therapy	pay for your inpatient stay. Cost shares for independently billed professional services (e.g., PCP or Specialist visits) received while you are an inpatient will be as below: **In-Network:** $0 co-payment for primary care physician services received in an inpatient setting. $0 co-payment for specialist physician services received in an inpatient setting. $0 co-payment for Medicare-covered lab services (e.g., urinalysis). $20 co-payment for Medicare-covered diagnostic procedures and tests (e.g., allergy test, cardiac stress test or EKG). $150 co-payment for Medicare-covered diagnostic radiology

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)	
	services. 20% of the cost for Medicare-covered therapeutic radiology services. $0 co-payment for Medicare-covered X-ray services. $0 co-payment for Medicare-covered Blood Services. 20% of the cost for Medicare-covered medical supplies. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for primary care physician services received in an inpatient setting. 20% of the cost for specialist physician services received in an inpatient setting. 20% of the cost for Medicare-covered lab services (e.g., urinalysis).

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)	
	20% of the cost for Medicare-covered diagnostic procedures and tests (e.g., allergy test, cardiac stress test or EKG). 20% of the cost for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology services. 20% of the cost for Medicare-covered X-ray services. 20% of the cost for Medicare-covered Blood Services. 20% of the cost for Medicare-covered medical supplies. In addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-covered

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)	
	Services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, eyeglasses and contacts after cataract surgery, Part D prescription drugs and Medicare Part B prescription drugs, as described in this Benefit Chart.
Meals benefit ***Prior Authorization (approval in advance) may be required*** Post-Acute Meals - For members discharged within two weeks from an inpatient facility (Hospital, Skilled Nursing Facility or Inpatient Rehabilitation) the plan will provide a maximum of 3 meals per day for 14-days for a total of 42 meals at no extra cost to you. Chronic Meals - For members with a chronic condition (AIDS, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery disease, diabetes, and hypertension). The chronic meal benefit must be part of a supervised program designed to transition you to life style modifications. There is a maximum of 3 meals per day for up to 28	$0 co-payment for each medically-necessary post-acute meal covered by the plan.* $0 co-payment for each medically-necessary chronic meal covered by the plan.*

Services that are covered for you	What you must pay when you get these services
Meals benefit (continued) days, for a maximum of 84 meals per month. The benefit may be received for up to 3 months.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-Network and Out-of-Network/Point-of-Service (POS):** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered MDPP benefit.
Medicare Part B prescription drugs	**In-Network:**

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs (continued)	
Prior Authorization (approval in advance) required to be covered These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: ● Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services ● Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ● Clotting factors you give yourself by injection if you have hemophilia ● Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ● Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug ● Antigens ● Certain oral anti-cancer drugs and anti-nausea drugs ● Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Procrit®) ● Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs	20% of the cost for Medicare Part B-covered chemotherapy drugs covered under Medicare Part B (Original Medicare). 20% of the cost for Part B-covered Drugs covered under Medicare Part B (Original Medicare). **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Part B-covered Drugs covered under Medicare Part B (Original Medicare). 20% of the cost for Part B-covered chemotherapy drugs covered under Medicare Part B (Original Medicare).

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs (continued) that may be subject to Step Therapy: http://www.wellcare.com/medicare We also cover some vaccines under our Part B prescription drug benefit.	
Non-emergency medical transportation ***Prior Authorization (approval in advance) may be required*** Non - emergency ground transportation within the plan's service area in order to obtain medically necessary care and services under the plan's benefits. Trips are limited to 75 miles, one-way, unless approved by the plan. Call at least 72 hours in advance to schedule routine trips. Call anytime for urgent trips. Certain locations may be excluded. For more information about plan-approved locations, please call Customer Service (phone numbers are printed on the back cover of this booklet). Vehicles may transport multiple occupants at the same time and may stop at locations other than the member's destination during the trip. Medically necessary transportation services must be for plan approved locations in order to be covered by the plan.	**In-Network:** $0 co-payment per trip for up to 24 one-way trips every year to plan approved locations
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care	**In-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss (continued)	
setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered preventive obesity screening and therapy. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Opioid treatment program services ***Prior Authorization (approval in advance) may be required.*** Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: ● FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable ● Substance use counseling ● Individual and group therapy	**In-Network:** $0 co-payment for Medicare-covered opioid treatment program services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered opioid treatment services.

Services that are covered for you	What you must pay when you get these services
Opioid treatment program services (continued) ● Toxicology testing	
Outpatient diagnostic tests and therapeutic services and supplies ***Prior Authorization (approval in advance) may be required*** Covered services include, but are not limited to: ● X-rays ● Radiation (radium and isotope) therapy including technician materials and supplies ● Chemotherapy services – see Medicare Part B prescription drugs in this Benefit Chart for the cost share for Medicare-covered Part B chemotherapy drugs ● Surgical supplies, such as dressings ● Splints, casts and other devices used to reduce fractures and dislocations ● Laboratory tests ● Blood - including storage and administration. Coverage of whole blood and packed red cells are covered beginning with the first pint used ● Other outpatient diagnostic tests ● Spirometry for chronic obstructive pulmonary disease (COPD). Spirometry is a common office test used to check how well your lungs are working once you're being treated for (COPD). ● Diagnostic Colonoscopy ● DEXA Scan	**In-Network:** $0 co-payment for Medicare-covered lab services (e.g., urinalysis). $0 co-payment for Spirometry for members with a diagnosis of COPD. $20 co-payment for Medicare-covered diagnostic tests and procedures (e.g., allergy test or EKG). $150 co-payment for Medicare-covered diagnostic radiology services (e.g., diagnostic colonoscopy) performed in an outpatient hospital. $100 co-payment for Medicare-covered diagnostic radiology services (not including X-rays) in a provider's office or freestanding facility. $0 co-payment for a DEXA

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	
	Scan. 20% of the cost for Medicare-covered therapeutic radiology received in a provider's office or freestanding facility. 20% of the cost for Medicare-covered therapeutic radiology services received in an outpatient hospital. $0 co-payment for Medicare-covered X-rays. $0 co-payment for unreplaced whole blood and/or packed red cells. 20% of the cost for Medicare-covered medical supplies. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered lab services (e.g., urinalysis). 20% of the cost for Medicare-covered

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	
	diagnostic procedures and tests. 20% of the cost for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology. 20% of the cost for Medicare-covered X-rays. 20% of the cost for Medicare-covered Blood Services. 20% of the cost for Medicare-covered medical supplies. In addition, DME/medical supplies, Medicare Part B Prescription Drugs, physician services and doctors office visit cost-share also applies. If you receive multiple services on the same day at the same facility, you will only be responsible to pay for the highest level of

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	
	service received. However, if the benefit for one service is a co-payment (fixed dollar amount) and the benefit for another service is a coinsurance (percentage of the allowed cost), you will be asked to pay both the co-payment and coinsurance.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.	**In-Network:** $120 co-payment when entering through the Emergency Room for hospital observation services. $150 co-payment when entering through an outpatient facility for observation services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for outpatient observation services.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation (continued) You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services ***Prior Authorization (approval in advance) may be required****, except for Emergency Services* We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: ● Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ● Laboratory and diagnostic tests billed by the hospital ● Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it ● X-rays and other radiology services billed by the hospital ● Medical supplies such as splints and casts ● Certain drugs and biologicals that you can't give yourself	**In-Network:** $150 co-payment for each Medicare-covered surgical visit to an outpatient hospital facility. $150 co-payment for each Medicare-covered non-surgical visit to an outpatient hospital facility, except when the following services are the only services performed, in which case cost-shares will be as below: $0 co-payment for primary care physician services at a hospital-owned clinic. $0 co-payment for specialist physician services at a hospital-owned clinic. $35 co-payment for

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	
	cardiac and $30 co-payment for pulmonary rehabilitation services performed at an outpatient hospital. 20% of the cost for renal dialysis performed in an outpatient hospital. $0 co-payment for Medicare-covered zero cost sharing preventive services performed in an outpatient hospital. $35 co-payment for occupational therapy performed in an outpatient hospital. $35 co-payment for physical therapy and speech language pathology services performed in an outpatient hospital. $20 co-payment for Medicare-covered diagnostic tests and procedures (e.g., allergy test or EKG). $0 co-payment for Medicare-covered lab

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	
	services (e.g., urinalysis). $0 co-payment for Medicare-covered X-ray services. $150 co-payment for Medicare-covered diagnostic radiology services performed in an outpatient hospital. 20% of the cost for Medicare-covered therapeutic radiology services performed in an outpatient hospital. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered surgical visit to an outpatient hospital facility. 20% of the cost for each Medicare-covered non-surgical visit to an outpatient hospital facility, except when the following services are the only services performed, in which case cost-shares will be as below:

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	
	20% of the cost for primary care physician services at a hospital-owned clinic. 20% of the cost for specialist physician services at a hospital-owned clinic. 20% of the cost for cardiac and pulmonary rehabilitation services performed at an outpatient hospital. 20% of the cost for renal dialysis performed in an outpatient hospital. 20% of the cost for Medicare-covered zero cost sharing preventive services performed in an outpatient hospital. 20% of the cost for occupational therapy performed in an outpatient hospital. 20% of the cost for physical therapy and speech language pathology services performed in an outpatient hospital.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	
	20% of the cost for Medicare-covered diagnostic tests and procedures (e.g., allergy test or EKG). 20% of the cost for Medicare-covered lab services (e.g., urinalysis). 20% of the cost for Medicare-covered X-ray services. 20% of the cost for Medicare-covered diagnostic radiology services performed in an outpatient hospital. 20% of the cost for Medicare-covered therapeutic radiology services performed in an outpatient hospital.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.	If you receive multiple services on the same day at the same facility, you will only be responsible to pay for the highest level of service received. However, if the benefit for one service is a co-payment (fixed dollar

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued) You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	amount) and the benefit for another service is a coinsurance (percentage of the allowed cost), you may be asked to pay both the co-payment and coinsurance.
Outpatient mental health care ***Prior Authorization (approval in advance) may be required*** Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Outpatient mental health care includes psychiatric services.	**In-Network:** $40 co-payment for each Medicare-covered (individual or group) therapy visit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered (individual or group) therapy visit.
Outpatient rehabilitation services ***Prior Authorization (approval in advance) may be required*** Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various	**In-Network:** $35 co-payment for each Medicare-covered occupational therapy visit. $35 co-payment for each Medicare-covered physical and speech-language

Services that are covered for you	What you must pay when you get these services
Outpatient rehabilitation services (continued)	
outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	therapy visit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered physical and speech-language therapy visit. 20% of the cost for each Medicare-covered occupational therapy visit. If these services are provided in your home, then the home health cost-share applies instead of the above. There will also be a co-payment and/or coinsurance for Medically Necessary Medicare-covered services for Durable Medical Equipment, prosthetic devices, certain medical supplies, Part D prescription drugs and Medicare Part B prescription drugs, where applicable.
Outpatient substance abuse services	**In-Network:**

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services (continued) ***Prior Authorization (approval in advance) may be required*** Outpatient mental health care for the diagnosis and/or treatment of substance-abuse related disorders.	$40 co-payment for each Medicare-covered (individual or group) therapy visit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered (individual or group) therapy visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers ***Prior Authorization (approval in advance) may be required*** **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	**In-Network:** $100 co-payment for each Medicare-covered ambulatory surgical center visit. $150 co-payment for each Medicare-covered surgical visit to an outpatient hospital facility. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered surgical visit to an outpatient hospital facility. 20% of the cost for each Medicare-covered ambulatory surgical center

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (Continued)	visit.
Over-the-Counter Items ***Prior Authorization (approval in advance) may be required*** The maximum total annual benefit is $600. You receive a benefit of $150 every quarter to spend on eligible over-the-counter (OTC) products. Only you can use your benefit, and the OTC products are intended for your use only. Getting your items is easy: You have the flexibility of purchasing eligible OTC items either in store or via a catalog. Items can be purchased in-store at a participating CVS retailer with your Member ID Card. You can also place an order via the catalog online at www.cvs.com/otchs/wellcare or over the phone by calling 866-918-2516, and we'll deliver your items to your door at no additional cost to you. Please note, the OTC catalog may change every year. Be sure to review the current catalog to see what items are new and to identify any changes to items from last year. There is a limit of 3 orders per quarter and there are limitations to how many of the same item can be ordered. This benefit does not carry over to the next period Please contact Customer Service for additional benefit details (phone numbers are printed on the back cover of this booklet). Note: Coverage of over-the-counter items is a	**In-Network:** There is no coinsurance, co-payment, or deductible for over-the-counter items. **Out-of-Network/Point-of-Service (POS):** The in-network provider must be used for the out-of-network benefit.

Services that are covered for you	What you must pay when you get these services
Over-the-Counter Items (continued) supplemental benefit offered by the plan. Neither Medicare nor Medicaid will pay your share of the cost for these items. Note: Under certain circumstances diagnostic equipment (such as equipment diagnosing blood pressure, cholesterol, diabetes, colorectal screenings, and HIV) and smoking-cessation aids are covered under the plan's medical benefits. To obtain the items and equipment listed above, you should (when possible) use your plan's other benefits rather than spending your OTC dollar allowance.	
Partial hospitalization services ***Prior Authorization (approval in advance) may be required*** "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network:** $55 co-payment per day for Medicare-covered partial hospitalization services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered partial hospitalization services.
Physician/Practitioner services, including doctor's office visits ***Prior Authorization (approval in advance) may be required****, except for primary care services* Covered services include: ● Medically-necessary medical care or surgery	**In-Network:** $0 co-payment for each Medicare-covered primary care visit. $0 co-payment for each Medicare-covered specialist visit.

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued)	
services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location ● Consultation, diagnosis, and treatment by a specialist ● Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment ● Certain telehealth services including: Urgently Needed Services, Home Health Services, Primary Care Physician, Occupational Therapy, Specialist, Individual Sessions for Mental Health, Podiatry Services, Other Health Care Professional, Individual Sessions for Psychiatric, Physical Therapy and Speech-Language Pathology Services, Individual Sessions for Outpatient Substance Abuse, and Diabetes Self-Management Training. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth ○ For more information regarding the telehealth benefit, please call 1-800-TEL-ADOC (1-800-835-2362) ● Some telehealth services including consultation, diagnosis, and treatment by a physician or practioner, for patients in certain rural areas or other places approved by Medicare ● Telehealth services for monthly end-stage renal disease-related visits for home dialysis members	$0 co-payment for each visit to other healthcare professionals in a primary care office or clinic or pharmacy setting for Medicare-covered services. $0 co-payment for services performed through Teladoc. Please note: The $0 co-payment above, only applies when services are received from Teladoc. If you receive in-person or telemedicine services from a network provider and not the telemedicine vendor, you will pay the cost shares listed for those providers as outlined within this benefit chart (e.g., if you receive telemedicine services from your PCP, you will pay the PCP cost share). In addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-covered

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued)	
in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home ● Telehealth services to diagnose, evaluate, or treat symptoms of a stroke ● Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment ● Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment ● Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient ● Second opinion by another network provider prior to surgery ● Non-routine dental care (covered services are limited to surgery of the jaw or related structures,	Services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, eyeglasses and contacts after cataract surgery, Part D prescription drugs and Medicare Part B prescription drugs, as described in this Benefit Chart. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered primary care visit. 20% of the cost for each visit to an Other Healthcare Provider in a primary care office. 20% of the cost for each Medicare-covered specialist visit. 20% of the cost for each visit to other health care professionals in a clinic or pharmacy setting for Medicare-covered

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	services.
Podiatry services ***Prior Authorization (approval in advance) may be required*** Covered services include: ● Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) ● Routine foot care for members with certain medical conditions affecting the lower limbs	**In-Network:** $0 co-payment for Medicare-covered podiatry services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered podiatry services.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: ● Digital rectal exam ● Prostate Specific Antigen (PSA) test	**In-Network:** There is no coinsurance, copayment, or deductible for an annual PSA test. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered prostate cancer screening exams. If your physician performs

Services that are covered for you	What you must pay when you get these services
Prostate cancer screening exams (continued)	additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Prosthetic devices and related supplies ***Prior Authorization (approval in advance) may be required*** Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see “Vision Care” later in this section for more detail.	**In-Network:** 20% of the cost for Medicare-covered prosthetics and orthotics. 20% of the cost for related supplies obtained from an outpatient hospital. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered prosthetics and orthotics. 20% of the cost for related supplies obtained from an outpatient hospital.

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services ***Prior Authorization (approval in advance) may be required*** Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-Network:** $30 co-payment for Medicare-covered pulmonary rehabilitation services. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered pulmonary rehabilitation services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered screening and counseling to reduce alcohol misuse. If your physician performs additional diagnostic or surgical procedures or if other medical services are

Services that are covered for you	What you must pay when you get these services
Screening and counseling to reduce alcohol misuse (continued)	
	provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
 **Screening for lung cancer with low dose computed tomography (LDCT)** For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered counseling and shared decision making visit or for the LDCT. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) (continued)	
	those services rendered during that visit.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered screening for sexually transmitted infections (STIs) and counseling to prevent STIs. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered services include: ● Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime ● Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) ● Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) ● Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) ● Home dialysis equipment and supplies ● Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	**In-Network:** 20% of the cost for Medicare-covered kidney disease education services. 20% of the cost for Medicare-covered outpatient renal dialysis treatments, self-dialysis training, and home support services. 20% of the cost for Medicare-covered home dialysis equipment. 20% of the cost for Medicare-covered dialysis supplies obtained from an outpatient hospital. 20% of the cost for Medicare-covered home dialysis supplies obtained from any other network location. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered kidney disease education services.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease (continued)	
	20% of the cost for Medicare-covered outpatient renal dialysis treatments and dialysis treatments in a home setting. 20% of the cost for Medicare-covered home dialysis equipment. 20% of the cost for Medicare-covered dialysis supplies obtained from an outpatient hospital. 20% of the cost for Medicare-covered home dialysis supplies obtained from any other network location. Staff-assisted home dialysis using nurses to assist End-Stage Renal Disease (ESRD) beneficiaries is not included in the End-Stage Renal Disease Prospective Payment System (ESRD PPS) and is not a Medicare-covered service. See "Inpatient Hospital Care" for cost shares

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease (continued)	
	applicable to inpatient dialysis treatments.
Skilled nursing facility (SNF) care ***Prior Authorization (approval in advance) required to be covered*** (For a definition of "skilled nursing facility care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Up to 100 days per benefit period of confinement and skilled care services in SNF or alternate setting are covered services when such services meet the Plan's and Medicare coverage guidelines. Medicare's requirement that a patient spend at least three (3) consecutive days in a hospital for a related condition before transferring to a SNF is not required. The 100-day per benefit period includes SNF days received through the Plan, Original Medicare or any other Medicare Advantage Organization during the benefit period. Covered services include but are not limited to: ● Semiprivate room (or a private room if medically necessary) ● Meals, including special diets ● Skilled nursing services ● Physical therapy, occupational therapy, and speech therapy ● Drugs administered to you as part of your plan of care (This includes substances that are naturally	**In-Network:** $0 co-pay per day for days 1-20 and a $165.00 co-pay per day for days 21-100. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for each Medicare-covered Skilled nursing facility (SNF) stay. No prior hospital stay is required. Our plan covers up to 100 days each benefit period. A benefit period begins on the first day you go into a skilled nursing facility (SNF). The benefit period ends when you haven't received any care in a skilled nursing facility (SNF) for 60 consecutive days. If you go into a skilled nursing facility after one benefit period has

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (continued) present in the body, such as blood clotting factors.) ● Blood - including storage and administration. Coverage of whole blood and packed red cells are covered beginning with the first pint used ● Medical and surgical supplies ordinarily provided by SNFs ● Laboratory tests ordinarily provided by SNFs ● X-rays and other radiology services ordinarily provided by SNFs ● Use of appliances such as wheelchairs ordinarily provided by SNFs ● Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider if the facility accepts our plan's amounts for payment. ● A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) ● A SNF where your spouse is living at the time you leave the hospital	ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. You are an inpatient in a SNF only if your care in a SNF meets certain standards for skilled Level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms	**In-Network:** There is no coinsurance, copayment, or deductible

Services that are covered for you	What you must pay when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued)	
of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered smoking cessation counseling services. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Supervised Exercise Therapy (SET) ***Prior Authorization (approval in advance) required to be covered*** SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	**In-Network:** $30 co-payment for Medicare-covered supervised exercise therapy services. **Out-of-Network/Point-of-Service (POS):**

Services that are covered for you	What you must pay when you get these services
Supervised Exercise Therapy (SET) (continued) The SET program must: ● Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication ● Be conducted in a hospital outpatient setting or a physician's office ● Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD ● Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	20% of the cost for Medicare-covered supervised exercise therapy services.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Outside the United States - Worldwide urgently needed services:**	$35 co-payment for Medicare-covered urgently needed services visits. If you are admitted to the hospital within 24 hours for the same condition, you pay $0 for the urgently needed services visit. In addition to the cost-share above, there will be a co-payment and/or coinsurance for Medically Necessary

Services that are covered for you	What you must pay when you get these services
Urgently needed services (continued)	
Urgently needed services or emergency room visits outside the United States are covered.	Medicare-covered services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, Part D prescription drugs and Medicare Part B prescription drugs, as described in this Benefit Chart. **Outside the United States - Worldwide urgently needed services:** $120 co-payment for urgently needed services visits outside the United States.* You are covered for up to $50,000 every year for emergency or urgently needed services outside the United States. The worldwide urgently needed services visit cost-share is not waived if you are admitted for inpatient hospital care. Urgently needed services may be received from both contracted and non-contracted urgent

Services that are covered for you	What you must pay when you get these services
Urgently needed services (continued)	
	care centers, as long as the urgent care center accepts Medicare. Services received from an urgent care center that does not accept Medicare will be the financial responsibility of the member.
Vision care ***Prior Authorization (approval in advance) may be required*** Covered services include: ● Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts ● For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older ● For people with diabetes, screening for diabetic retinopathy is covered once per year ● One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract	**In-Network:** $0 co-payment for Medicare-covered retinal exam for diabetic members. $0 co-payment for Medicare-covered glaucoma screening. $0 co-payment for all other eye exams to diagnose and treat diseases and conditions of the eye. $0 co-payment* for Medicare-covered eyewear, which, for our plan members, includes: ● Eye refractions for the purpose of prescribing Medicare-covered eyewear.

Services that are covered for you	What you must pay when you get these services
Vision care (continued)	
operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) ○ Our plan covers: ♦ Eye refractions when provided for the purpose of prescribing Medicare-covered eyewear. ♦ The contact lens fitting fee for Medicare-covered contact lenses. In addition, our plan covers the following supplemental (i.e., routine) vision services: ● 1 routine eye exam every year. The routine eye exam includes a glaucoma test for people who are at risk for glaucoma and a retinal exam for diabetics. ● Unlimited pairs of prescription eyewear every year. A maximum benefit of $200 every year for any of the following: ○ Eyeglasses (frame and lenses) or ○ Eyeglass lenses only or ○ Eyeglass frames only or ○ Contact lenses instead of eyeglasses Note: Contact lenses fitting fee is covered by the plan. Maximum plan benefit coverage amount of $200 every year applies to the retail cost of frames and/or lenses (including any lens options such as tints and coatings). Medicare-covered eyewear is not included in the supplemental (i.e., routine) benefit maximum.	● Contact lens fitting for Medicare-covered contact lenses. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered retinal exam for diabetic members. 20% of the cost for Medicare-covered Glaucoma screening. 20% of the cost for all other eye exams to diagnose and treat diseases and conditions of the eye. 20% of the cost* for Medicare-covered eyewear, which, for our plan members, includes: ● Eye refractions for the purpose of prescribing Medicare-covered eyewear. ● Contact lens fitting for Medicare-covered contact lenses. **Supplemental (i.e.,**

Services that are covered for you	What you must pay when you get these services
Vision care (continued) Note: You are responsible for any costs above the $200 maximum for supplemental (i.e., routine) eyewear.* Note: Supplemental (i.e., routine) vision services must be received from a participating provider in order to be covered by the plan. Members cannot use their supplemental eyewear benefit to increase their coverage on Medicare-covered eyewear.	**routine) vision services:** **In-Network:** $0 co-payment for 1 routine eye exam every year.* $0 co-payment for unlimited routine eyewear every year*
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**In-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. **Out-of-Network/Point-of-Service (POS):** 20% of the cost for the "Welcome to Medicare" preventive visit. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for

Services that are covered for you	What you must pay when you get these services
"Welcome to Medicare" preventive visit (continued)	
	those services rendered during that visit.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.		✓
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body part. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Home-delivered meals (post-acute)		✓
Home-delivered meals (chronic)		✓
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Radial keratotomy, LASIK surgery, and other low vision aids.	✓	
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture		✓
Naturopath services (uses natural or alternative treatments).	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Substance abuse detoxification and rehabilitation.		✓ Covered in accordance with Medicare guidelines, i.e., when the following conditions are met: ● You receive services from a Medicare-participating provider or facility; ● Your doctor states that the services are medically necessary; and ● Your doctor sets up your plan of treatment.

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

Asking us to pay our share of a bill you have received for covered medical services

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. **When you've received emergency or urgently needed medical care from a provider who is not in our plan's network**

   You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

   - If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

   - At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.

     - If the provider is owed anything, we will pay the provider directly.

- If you have already paid more than your share of the cost of the service, we will determine how much you are owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balancing billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.

- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person’s enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.wellcare.com/medicare) or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Mail your request for payment together with any bills or receipts to us at this address:

WellCare Health Plans
Medical Reimbursement Department
P.O. Box 31370
Tampa, FL 33631

You must submit your claim to us within 365 days of the date you received the service, item, or drug.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)

- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 4, you can go to Section 5.3 to learn how to make an appeal about getting paid back for a medical service.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We also have materials available in languages other than English that are spoken in the plan's service area. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service for additional information.

Para obtener información de una manera que le sea conveniente, llame al Servicio de Atención al Cliente (los números de teléfono se encuentran impresos en la parte posterior de este folleto).

Nuestro plan dispone de profesionales y servicios de interpretación gratuitos para atender preguntas de miembros con algún impedimento o que no hablen inglés. A parte del inglés, también disponemos de contenido para usted en otros idiomas habituales en el área de servicio del plan. Si lo precisara, podemos darle la información en braille, letra grande u otros formatos de forma gratuita. Tenemos la obligación de ofrecerle la información sobre los beneficios del plan en un formato que le resulte accesible y conveniente. Para obtener información de una manera que le sea conveniente, llame al Servicio de Atención al Cliente (los números de teléfono se encuentran impresos en la parte posterior de este folleto).

Si se encuentra con algún problema para poder recibir la información de nuestro plan en un formato que le resulte accesible y conveniente, llame para presentar una protesta ante el Servicio de Atención al Cliente (los números de teléfono se encuentran impresos en la parte posterior de este folleto). También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente a través de la Oficina de Derechos Civiles. En la presente Evidencia de Cobertura o correo se incluye la información de contacto. Para más información, también puede contactar con el Servicio de Atención al Cliente.

귀하에게 편리한 방식으로 정보를 얻으려면 저희 고객 서비스부로 전화해 주십시오(전화 번호는 이 소책자 뒷표지에 인쇄되어 있습니다).

저희 플랜은 장애인과 영어를 사용하지 않는 가입자들을 응대하기 위해 무료 통역 서비스와 지원 직원들을 두고 있습니다. 또한 플랜의 서비스 지역에서 사용되는 영어 이외의 언어로 자료를 준비해두고 있습니다. 저희는 또한 점자, 큰 활자 또는 다른 대체 형식으로 필요한 정보를 무료로 제공해드릴 수있습니다. 저희는 귀하에게 접근 가능하고 적절한 형식으로 플랜의 혜택정보를 제공해야 할 의무가 있습니다. 귀하에게 편리한 방식으로 정보를 얻으려면 저희 고객 서비스부(전화번호는 이 소책자 뒷표지에 인쇄되어 있습니다)에 전화해 주십시오.

플랜에서 제공하는 정보를 귀하가 이용할 수 있는 적절한 형식으로 입수하는데 문제가 있는 경우 고객 서비스부(전화번호는 이 책자 뒷 표지에 인쇄되어 있습니다)에 연락하여 불만 제기를 하실 수 있습니다. 또한 Medicare 에 1-800-MEDICARE(1-800-633-4227)로 전화를 하시어 불만 제기를 하실 수있으며 인권 사무소(Office for Civil Rights)에 직접 연락을 하실 수도있습니다. 연락정보는 본 보장범위 증명서 또는 본 우편에 포함되어 있으며추가 정보를 위해 고객 서비스부에 연락하셔도 됩니다.

Section 1.2 We must treat you with fairness, respect, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY: 1-800-537-7697), or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered services

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

WellCare Notice of Privacy Practices

We care about your privacy. You have a right to know how and when we share your medical information. You also have a right to see your information. This notice details how we share your information and how you may access it. Please read it carefully.

Effective Date of this Privacy Notice: March 29, 2012
Revised as of June 2020

We may change our privacy practices from time to time. If we make major changes, we will give you a copy of the new Privacy Notice. It will state when the changes take effect.

This Privacy Notice applies to the following WellCare entities:

- American Progressive Life and Health Insurance Company of New York
- Care 1st Health Plan Arizona, Inc.
- WellCare of California, Inc.
- Exactus Pharmacy Solutions, Inc.
- Harmony Health Plan, Inc.
- OneCare by Care1st Health Plan of Arizona, Inc.
- SelectCare of Texas, Inc.
- SelectCare Health Plans, Inc.
- WellCare Health Insurance Company of America
- WellCare Health Insurance of Arizona, Inc., which also operates in Hawai'i as 'Ohana Health Plan, Inc.
- WellCare Health Insurance Company of Kentucky, Inc., operating in Kentucky as WellCare of Kentucky, Inc.
- WellCare Health Insurance Company of Louisiana, Inc.
- WellCare Health Insurance Company of New Jersey, Inc.
- WellCare Health Insurance of New York, Inc.
- WellCare Health Insurance of the Southwest, Inc.
- WellCare of Alabama, Inc.
- WellCare of Connecticut, Inc.
- WellCare of Florida, Inc., d/b/a/ Staywell Health Plan of Florida
- Staywell Kids and Children's Medical Services Health Plan, operated by WellCare of Florida, Inc.
- WellCare of Florida, Inc.
- WellCare of Georgia, Inc.
- WellCare of Illinois, Inc.
- WellCare of Maine, Inc.
- WellCare of Mississippi, Inc.
- WellCare of New York, Inc.
- WellCare of North Carolina, Inc.
- WellCare of South Carolina, Inc.
- WellCare of Texas, Inc.
- WellCare of Washington, Inc.
- WellCare Prescription Insurance, Inc.
- WellCare Health Plans of Arizona, Inc.
- Meridian Health Plan of Illinois, Inc.
- Meridian Health Plan of Michigan, Inc.

- WellCare Health Plans of Missouri, Inc.
- WellCare Health Plans of New Jersey, Inc.
- WellCare Health Plans of Rhode Island, Inc.
- WellCare Health Plans of Vermont, Inc.
- MeridianRX, LLC
- WellCare Health Insurance Company of New Hampshire, Inc.
- WellCare Health Insurance of Connecticut, Inc.
- WellCare Health Insurance of North Carolina, Inc.
- WellCare National Health Insurance Company
- WellCare of Missouri Health Insurance Company, Inc.
- WellCare of New Hampshire, Inc.
- WellCare Health Insurance of Tennessee, Inc.
- WellCare of Tennessee, Inc.
- WellCare Health Insurance Company of Washington, Inc.

How We May Use and Share Your Health Information without Written Permission

WellCare has rules to protect your privacy. WellCare requires its employees to protect your health information in oral, written and electronic form. However, these are situations where we do not need your written permission to use your health information or to share it with others:

1. Treatment, Payment and Business Operations

We may have to share your health information to help treat you. We may share it to make sure providers are paid and other business reasons. For example:

Treatment:

- We may share your information with a healthcare provider who is treating you.
- For example, we may let the provider know what prescription drugs you are taking.

Payment:

- To give you health coverage and benefits, we must do things like collect premiums and make sure providers are paid for their services.
- We use your health information to do these financial tasks.

Healthcare Operations:

- We may share your information for our healthcare operations.
- This help s protect members from fraud, waste and abuse.
- It also helps us work on customer service issues and grievances.

Treatment Alternatives and Benefits and Services:

- We may use your health information to tell you about treatment options available to you.
- We will remind you about appointments and tell you about benefits or services of interest to you.

Underwriting:

- We may use your health information for underwriting.
- Please note that we will not use your genetic information for underwriting.

Family Members, Relatives or Close Friends Involved in Your Care:

- Unless you object, we may share your health information with your family members, relatives or close friends who have your permission to be involved in your medical care.
- If you are unable to agree or object, we may decide whether sharing your information is in your best interest.
- If we decide to share your health information in such a case, we will only share the information needed for your treatment or payment.

Business Associates:

- We may share your information with a business associate who needs the information to work with us.
- We will do so only if the associate signs an agreement to protect your privacy.
- Examples of business associates include auditors, lawyers and consultants.

2. Public Need

We may use and share your health information to comply with the law or to meet important public needs that are described below:

- The law requires us to do so.
- When public health officials need the information for public health matters.
- When government agencies need the information for such things as audits, investigations and inspections.
- If we believe you have been a victim of abuse, neglect or domestic violence.
- If your information is needed by a person or company regulated by the Food and Drug Administration (FDA): to report or track product defects; to repair, replace, or recall defective products; or to keep track of a product after the FDA approves it for use by the public.
- If a court orders us to release your information.
- When law enforcement officials need the information to comply with court orders or laws, or to help find a suspect, fugitive, witness or missing person.
- To prevent a serious health threat to you, another person or the public – we will only share the information with someone able to help prevent the threat.
- For research.
- When the information is needed by law for workers' compensation or other programs that cover work-related injury or illness that do not relate to fraud.
- If your information is needed by military officials for a mission.
- When federal officials need the information to work on national security or intelligence, or to protect the President or other officials.
- To prison officers who need the information to give you healthcare or maintain safety at the place where you are confined.

- In the unfortunate event of your death, to a coroner or medical examiner, for example, to determine the cause of death.
- To funeral directors so they can carry out their duties.
- In the unfortunate event of your death, to organizations that store organs, eyes or other tissues so they may find out whether donation or transplant is allowed by law.

3. Completely De-Identified and Partially De-Identified Information.

These are two types of information you should know about:

- "**Completely de-identified**" health information: We share this only after taking out anything that could tell someone else who you are.
- "**Partially de-identified**" health information: Will not contain any information that would directly identify you (such as your name, street address, Social Security number, phone number, fax number, electronic mail address, website address or license number).
- We share partially de-identified information only for public health, research or for business operations, and the person who receives it must sign an agreement to protect your privacy as required by law.

Requirement for Written Authorization

Earlier in this notice, we listed some of the reasons we may use your health information without your written authorization, including:

- Treatment
- Payment
- Healthcare operations
- Other reasons listed in this notice

However, we need your written authorization to use your health information for other reasons, which may include:

- Disclosures of psychotherapy notes (where appropriate)
- Marketing purposes
- Disclosures for selling health information

You may end your authorization in writing at any time.

Your Rights to Access and Control Your Health Information

We want you to know about these rights.

1. Right to Access Your Health Information.

You can get a copy of your health information except for information:

- Contained in psychotherapy notes.
- Gathered in anticipation of, or for use in, a civil, criminal or administrative proceeding.
- With some exceptions, information subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA).

We may have electronic health records (EHR) for you. You have the right to get these in electronic format. You may ask us to send a copy of your EHR to a third party that you choose.

How to access your health information:

- Send your written request to the address listed later in this Privacy Notice.
- In most cases we will respond within 30 days if we have the information in our facility.
- We will respond within 60 days if it is in another facility.
- We will let you know if we need more time to respond.

We may charge you a fee to cover costs like postage. If you ask for a copy of an EHR, we will not charge you any more than our labor costs.

We may not give you access to your health information if it:

- Is reasonably likely to put you or someone else in danger.
- Refers to another person and a licensed healthcare professional finds your access is likely to harm that person.
- A licensed healthcare professional determines that your access as the representative of another person is likely to cause harm to that person or any other person.

If we turn down your request for one of these reasons, you can ask for a review. You have a right to get a written explanation of the reasons for denial.

2. You Have the Right to Change Health Information That Is Not Correct

You may ask us to change information that you believe is wrong or not complete. Ask us in writing. We will reply within 60 days. We may not have the information. If that is the case, we will tell you how to reach someone who does. In some cases we may deny your request. You may then state that you disagree. You can ask that your statement be included when we share your information in the future.

3. You Have a Right to Know When We Share Your Information

You can ask us for an accounting of disclosures of your health information in the past six years. Our response will not include disclosures:

- For payment, treatment or healthcare operations made to you or your personal representative.
- That you authorized in writing.
- Made to family and friends involved in your care or payment for your care.
- For research, public health or our business operations.
- Made to federal officials for national security and intelligence activities made to correctional institutions or law enforcement.
- Uses or disclosures otherwise permitted or required by law.

How to ask for an accounting of disclosures:

- Write to the address listed later in this Privacy Notice.
- If we do not have your health information, we will give you the contact information of someone who does.
- We will respond within 60 days.

You can get one free request each year. We may charge a fee for more requests within the same 12 months.

4. You Have a Right to Ask for Additional Privacy Protections

You can ask us to put more restrictions on the use or disclosure of your health information. If we agree to your request, we will put these restrictions in place except in an emergency. We do not need to agree to the restriction unless:

- The disclosure is needed for payment or healthcare operations and is not otherwise required by law.
- The health information relates only to a healthcare item or service that you or someone on your behalf has paid for out of pocket and in full.

You can end the restrictions at any time.

5. You Have the Right to Ask for Confidential Communications

You can ask us to communicate with you in alternative ways.

How to request alternative communications:

- Send your request to the address listed later in this Privacy Notice.
- Clearly state in your request that disclosure of your health information could endanger you and list how or where you want to get communications.

6. You Have a Right to Know of a Breach

The law requires us to keep your health information private. We take steps to protect information in electronic files. When someone has unauthorized access, it is called a breach. We will tell you if that happens. In some cases we will post a notice on our website (**www.wellcare.com**) or in a news outlet in your area.

7. You Have a Right to Get a Paper Copy of This Notice

You can ask for a paper copy of this notice. Please send your written request to the address on this page of this Privacy Notice. You can also visit our website at **www.wellcare.com**.

Miscellaneous

1. How to Contact Us

Let us know if you have questions about this Privacy Notice. You can reach us in one of the following ways:

- Call our Privacy Officer at **1-888-240-4946** (TTY **711**)
- Call the toll-free number on the back of your membership card
- Visit **www.wellcare.com**
- Write to us at:

WellCare Health Plans, Inc.
Attention: Privacy Officer
P.O. Box 31386
Tampa, FL 33631-3386

2. Complaints

You may complain if you feel we have violated your privacy rights. You can do this by reaching us in one of the ways listed above. You also may send a written complaint to the U.S. Department of Health and Human Services. We will not act against you for complaining. It is your right.

3. Other Rights

This Privacy Notice explains your rights under federal law. But some state laws may give you even greater rights. These may include more favorable access and amendment rights. Some state laws may give you more protection for sensitive information in these areas:

- HIV/AIDS
- Mental health
- Alcohol and drug abuse
- Reproductive health
- Sexually transmitted diseases

If the law in your state gives you greater rights than those listed in this notice, we will comply with the law in your state.

Section 1.5 We must give you information about the plan, its network of providers, your covered services, and your rights and responsibilities

As a member of our plan, you have the right to get several kinds of information from us. (As explained in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the *Provider Directory*.
  - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.wellcare.com/medicare.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - We look at new technology when requested by a member. The findings are reviewed annually to determine how new advancements can be included in the benefits that members receive, to make sure that members have fair access to safe and effective care, and to make sure that we are aware of changes in the industry. New technology may include behavioral health procedures, medical devices, medical procedures, and pharmaceuticals, for example.

- If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or

treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for

you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Georgia Department of Public Health.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do - ask for a coverage decision, make an appeal, or make a complaint - **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 You have the right to make recommendations as well as get more information about your rights and responsibilities

There are several places where you can get more information about your rights:

- You have the right to make recommendations regarding the plan's rights and responsibilities policy.
- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.

- You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf);
- Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the

information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again. You have the responsibility to understand your health problems and help set treatment goals that you and your doctor agree upon.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
  - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

- **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals.**
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- You **can get free help** from your SHIP (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care, or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.wellcare.com/medicare.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you

qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. The term “medical care” includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
        - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
        - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and CORF services.

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **"fast coverage decision."**

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we received your request.

- **However,** for a request **for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
  - **However,** for a request **for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received.* (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.

- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.

- For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

<u>Step 3:</u> If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 *(How to contact us when you are making an appeal about your medical care)*.
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.wellcare.com/medicare.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days, if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization

can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3

and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 Appeal.

- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.

- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and your right to know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.

- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your SHIP, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

<u>Step 1:</u> Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or co-payments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal"**.

<u>Step 1:</u> Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

<u>Step 2:</u> We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the "standard" deadlines for giving you the answer to this review.

<u>Step 3:</u> We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of

care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

<u>Step 2:</u> The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

<u>Step 3:</u> If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.

- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms
In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)
The written notice is called the "**Notice of Medicare Non-Coverage."**

2. You will be asked to sign the written notice to show that you received it.

- You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines,

you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)

- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are on the back cover of this booklet). Or call your SHIP, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

<u>Step 1:</u> Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by *noon of the day before the effective date on the Notice of Medicare Non-Coverage.*
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you can make your appeal directly to us

instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or co-payments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal"**.

Step 1: Contact us and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

- We will use the "fast" deadlines rather than the "standard" deadlines for giving you the answer to this review.

<u>Step 3:</u> We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

<u>Step 4:</u> If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At

Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal **A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.

- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may or may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	● Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	● Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	● Has someone been rude or disrespectful to you? ● Are you unhappy with how our Customer Service has treated you? ● Do you feel you are being encouraged to leave the plan?
Waiting times	● Are you having trouble getting an appointment, or waiting too long to get it? ● Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	● Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	● Do you believe we have not given you a notice that we are required to give? ● Do you think written information we have given you is hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: ● If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. ● If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. ● When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. ● When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

<u>Step 1:</u> Contact us promptly - either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. 1-866-892-8340, TTY/TDD users call 711, Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- An **Expedited** grievance (fast complaint) is resolved within 24 hours.
- A **Standard** grievance (Complaint) is generally resolved within 30 calendar days from the date we receive your request unless your health or condition requires a quicker response. If additional information is required or you ask for an extension, we may extend the timeframe by up to 14 calendar days. A Grievance Coordinator will contact you and/or your representative with the resolution.
- A grievance (complaint) can be submitted in writing by mail, web or fax. Send your request to:

WellCare
Attn: Grievance Department
P.O. Box 31384, Tampa, FL 33631-3384
Fax to: 1-866-388-1769
https://www.wellcare.com/Contact-Us/Contact-Us-Form

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or "fast appeal," we will automatically give you a "fast complaint".** If you have a "fast complaint", it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Open Enrollment Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.

- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - *- or -* Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.

- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:

  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)

  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - - *or* - Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2021*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
● Another Medicare health plan.	● Enroll in the new Medicare health plan. You will automatically be disenrolled from WellCare Patriot (HMO-POS) when your new plan's coverage begins.
● Original Medicare *with* a separate Medicare prescription drug plan.	● Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from WellCare Patriot (HMO-POS) when your new plan's coverage begins.
● Original Medicare *without* a separate Medicare prescription drug plan.	● **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). ● You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. ● You will be disenrolled from WellCare Patriot (HMO-POS) when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new

coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 WellCare Patriot (HMO-POS) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

WellCare Patriot (HMO-POS) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

WellCare Patriot (HMO-POS) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9
Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Discrimination is Against the Law

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare Health Plans, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact WellCare Customer Service for help or you can ask Customer Service to put you in touch with a Civil Rights Coordinator who works for WellCare.

If you believe that WellCare Health Plans, Inc., has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

WellCare Health Plans, Inc.
Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384
Telephone: **1-866-530-9491** TTY: **711** Fax: **1-866-388-1769** Email: **OperationalGrievance@wellcare.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a WellCare Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, **800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

* This Nondiscrimination Notice also applies to all subsidiaries of WellCare Health Plans, Inc.

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SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, WellCare Patriot (HMO-POS), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about third party liability and overpayments

There may be instances when a third party or other insurance is responsible for covering the cost of a member's health care expenses. If our plan provides health care benefits to a member for injuries or illness for which another party is responsible, then our plan has the right to repayment of the full cost of all benefits provided by us on behalf of the member.

If the benefits paid by our plan, plus the benefits paid by any third party, including other insurance plans, exceed the total amount of expenses actually incurred, then our plan has the right to recover the amount of such excess payment.

You are required to cooperate with us in pursuing such recoveries or over payments.

SECTION 5 Independent contractors

The relationship between our plan and participating providers is an independent contractor relationship. Participating providers are not employees or agents of our plan. In no case shall our plan be liable for the negligence, wrongful acts or omissions of any participating providers.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Allowed Amount – Maximum amount on which payment is based for covered health care services. This may be called "eligible expense", "payment allowance" or "negotiated rate". If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.) Network providers cannot charge more than the allowed amount for a service.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Deductible – The amount you must pay for health care before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Flex Card – A debit card, prepaid by the plan, that may be used to help pay for out-of-pocket expenses at dental, vision, and hearing providers that accept VISA.

Grievance – A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the

toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Independent Practice Association (IPA) – An association of physicians, including PCPs and specialists, and other health care providers, including hospitals, that is contracted with the plan to provide services to members. See Chapter 1, Section 5.1.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Limiting Charge – An out-of-network physician who accepts Medicare can only balance bill you up to the Limiting Charge. By law, the Limiting Charge is 15% over the Medicare-approved amount for physician services. There is no Limiting Charge for out-of-network providers of durable medical equipment and supplies, or for any provider who does not accept Medicare.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Charge – The amount set by an insurance company as the highest amount than can be charged for a particular medical service.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medical Group – An association of physicians, including PCPs and specialists, and other health care providers, including hospitals, that contract with the plan to provide services to enrollees. See Chapter 1, Section 3.2.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, or a Medicare Advantage plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Our plan does not offer Medicare prescription drug coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – A network is part of having a Medicare Advantage plan. When a doctor or hospital contracts with us, it means they're in network. We also call them participating providers. Doctors or hospitals that don't contract with us are considered out of network.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Opioid Treatment Program – a program or practitioner engaged in opioid treatment of individuals with an opioid agonist and antagonist medication.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay

your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Point-of-Service – The Point-of-Service (POS) Option is an additional benefit that covers certain medically necessary services you may get from out-of-network providers who accept Medicare. When you use your POS (out-of-network) benefit you are responsible for more of the cost of care. Always talk to your Primary Care Provider (PCP) before seeking care from an out-of-network provider. Your PCP will notify us by requesting approval from the plan ("prior authorization").(See Chapter 1, Section 1.1)

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

WellCare Patriot (HMO-POS) Customer Service

Method	Customer Service - Contact Information
CALL	1-866-892-8340 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
FAX	1-877-297-3112
WRITE	WellCare Health Plans Customer Service, PO Box 31370 Tampa, FL 33631
WEBSITE	www.wellcare.com/medicare

GeorgiaCares (Georgia SHIP)

GeorgiaCares is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-866-552-4464
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	GeorgiaCares 2 Peachtree Street, NW, 33rd Floor Atlanta, GA 30303
WEBSITE	http://www.mygeorgiacares.org

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