

2010

Summary of Benefits

WellCare | Coordinated Care Plans



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CONNECTICUT

Fairfield, Hartford, New Haven and Tolland
Counties

WellCare of Connecticut, Inc. | H0712

01/01/10 - 12/31/10

WellCare Access (HMO) | Plan 005

Section I - Introduction to the Summary of Benefits

Thank you for your interest in WellCare Access (HMO). Our plan is offered by WellCare of Connecticut, Inc., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost-sharing in this Summary of Benefits is based on your level of Medicaid eligibility.

Please call WellCare Access (HMO) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call WellCare Access (HMO) and ask for the "Evidence of Coverage."

You have choices in your health care.

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like WellCare Access (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call WellCare Access (HMO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How can I compare my options?

You can compare WellCare Access (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where is WellCare Access (HMO) available?

The service area for this plan includes: Fairfield, Hartford, New Haven, and Tolland counties, CT. You must live in one of these areas to join the plan.

Who is eligible to join WellCare Access (HMO)?

You can join WellCare Access (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease generally are not eligible to enroll in WellCare Access (HMO) unless they are members of our organization and have been since their dialysis began.

You must also be enrolled in the Department of Social Services to join this plan.

Please call the plan to see if you are eligible to join.

Can I choose my doctors?

WellCare Access (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at our Web site.

Our Customer Service number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither WellCare Access (HMO) nor the Original Medicare Plan will pay for these services.

Does my plan cover Medicare Part B or Part D drugs?

WellCare Access (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where can I get my prescriptions if I join this plan?

WellCare Access (HMO) has formed a network of pharmacies. You must use a network pharmacy

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to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.wellcare.com. Our Customer Service number is listed at the end of this introduction.

What is a prescription drug formulary?

WellCare Access (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.wellcare.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with my prescription drug plan costs?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your state Medicaid office.

What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of WellCare Access (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we

deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidigm 1-800-553-7590 (TTY 711).

As a member of WellCare Access (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost-utilization rules, such as a limit on the quantity

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of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidigm 1-800-553-7590 (TTY 711).

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact WellCare Access (HMO) for more details.

What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following

types of drugs. Contact WellCare Access (HMO) for more details.

Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have End-Stage Renal Disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

Injectable Drugs: Most injectable drugs administered incident to a physician's service.

Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

Some Oral Cancer Drugs: If the same drug is available in injectable form.

Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

Inhalation and Infusion Drugs provided through DME.

Plan Ratings

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the Web, you may use the Web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-866-635-7047 to obtain a copy of the plan ratings for this plan. TTY/TDD users call 1-877-247-6272.

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Please call WellCare for more information about WellCare Access (HMO).

Visit us at www.wellcare.com or call us:

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8am to 9pm, Eastern

Current members should call toll-free 1-866-635-7047 for questions related to the **Medicare Advantage** program or the **Medicare Part D Prescription Drug** program (TTY/TDD 1-877-247-6272).

Prospective members should call toll-free 1-866-238-4344 for questions related to the **Medicare Advantage** program or the **Medicare Part D Prescription Drug** program (TTY/TDD 1-877-247-6272).

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the Web.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact WellCare for details.

Section II - Summary of Benefits

For Contract H0712 | Plan 005

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>Important Information</p> <p>1 - Premium and Other Important Information</p>	<p>In 2010 the monthly Part B Premium is \$0 and the yearly Part B deductible amount is \$0.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General</p> <p>\$0 to \$34.60 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>*All cost-sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p>\$0 yearly deductible.*</p> <p>In-Network</p> <p>\$0 yearly deductible.*</p> <p>Out-of-Network</p> <p>\$0 yearly deductible.*</p> <p>In and Out-of-Network</p> <p>\$0 yearly deductible.*</p>
<p>2 - Doctor and Hospital Choice</p> <p>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network specialists (for certain benefits).</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>Inpatient Care</p> <p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>For each benefit period:</p> <ul style="list-style-type: none"> • Days 1 - 60: \$0 deductible* • Days 61 - 90: \$0 per day* • Days 91 - 150: \$0 per lifetime reserve day* <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>	<p>In-Network</p> <p>You will not be charged additional cost-sharing for professional services.</p> <p>\$0 yearly deductible*</p> <p>\$0 co-pay*</p> <p>Plan covers 90 days each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>4 - Inpatient Mental Health Care</p>	<p>Same deductible and co-pay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p>In-Network</p> <p>Same deductible and co-pay as inpatient hospital care (see “Inpatient Hospital Care”).</p> <p>\$0 yearly deductible*</p> <p>\$0 co-pay*</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>5 - Skilled Nursing Facility (SNF) (in a Medicare-certified Skilled Nursing Facility)</p>	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <ul style="list-style-type: none"> • Days 1 - 20: \$0 per day* • Days 21 - 100: \$0 per day* <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 yearly deductible* \$0 co-pay for SNF services*</p> <p>You will not be charged additional cost-sharing for professional services.</p> <p>For non-Medicare-covered SNF stays:</p> <ul style="list-style-type: none"> • Days 1 - 20: \$0 per day • Days 21 - 100: \$0 per day <p>Plan covers up to 100 days each benefit period. No prior hospital stay is required.</p>
<p>6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 co-pay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered home health visits.*</p>
<p>7 - Hospice</p>	<p>You pay part of the cost for outpatient drugs.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>Outpatient Care</p> <p>8 - Doctor Office Visits</p>	<p>0% coinsurance</p>	<p>General See “Physical Exams,” for more information.</p> <p>In-Network \$0 co-pay for each primary care doctor visit for Medicare-covered benefits.* \$0 co-pay for the cost of each in-area, network urgent care Medicare-covered visit.* \$0 co-pay for each specialist doctor visit for Medicare-covered benefits.*</p>
<p>9 - Chiropractic Services</p>	<p>Routine care not covered. 0% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>In-Network \$0 co-pay for Medicare-covered chiropractic visits.* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
<p>10 - Podiatry Services</p>	<p>Routine care not covered. 0% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network \$0 co-pay for Medicare-covered podiatry benefits.* Medicare-covered podiatry benefits are for medically necessary foot care.</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>11 - Outpatient Mental Health Care</p>	<p>0% coinsurance for most outpatient mental health services.</p>	<p>In-Network \$0 co-pay for Medicare-covered Mental Health visits.* \$0 co-pay for each Medicare-covered visit with a psychiatrist.*</p>
<p>12 - Outpatient Substance Abuse Care</p>	<p>0% coinsurance</p>	<p>In-Network \$0 co-pay for Medicare-covered visits.*</p>
<p>13 - Outpatient Services/Surgery</p>	<p>0% coinsurance for the doctor. 0% of outpatient facility charges.</p>	<p>General Authorization rules may apply. In-Network \$0 co-pay for each Medicare-covered ambulatory surgical center visit.* \$0 co-pay for each Medicare-covered outpatient hospital facility visit.*</p>
<p>14 - Ambulance Services (medically necessary ambulance services)</p>	<p>0% coinsurance</p>	<p>In-Network \$0 co-pay for Medicare-covered ambulance benefits.*</p>
<p>15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>0% coinsurance for the doctor. 0% of facility charge or 0% per emergency room visit. You don't have to pay the emergency room co-pay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$0 co-pay for Medicare-covered emergency room visits.* Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% coinsurance NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$0 co-pay for Medicare-covered urgent-care visits.* If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.</p>
<p>17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>0% coinsurance</p>	<p>General Authorization rules may apply. In-Network \$0 co-pay for Medicare-covered Occupational Therapy visits.* \$0 co-pay for Medicare-covered Physical and/or Speech/Language Therapy visits.*</p>
<p>Outpatient Medical Services and Supplies 18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>0% coinsurance</p>	<p>General Authorization rules may apply. In-Network \$0 co-pay for Medicare-covered items.*</p>
<p>19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>0% coinsurance</p>	<p>General Authorization rules may apply. In-Network \$0 co-pay for Medicare-covered items.*</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>0% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietician or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Diabetes self-monitoring training.* \$0 co-pay for Nutrition Therapy for Diabetes.* \$0 co-pay for Diabetes supplies.*</p>
<p>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>0% coinsurance for diagnostic tests and X-rays. \$0 co-pay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services* • diagnostic procedures and tests* • X-rays.* • diagnostic radiology services (not including X-rays)* • therapeutic radiology services*
<p>Preventive Services</p> <p>22 - Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>0% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network \$0 co-pay for Medicare-covered bone mass measurement.*</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>23 - Colorectal Screening Exams (for people with Medicare age 50 and older)</p>	<p>0% coinsurance Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network \$0 co-pay for Medicare-covered colorectal screenings.*</p>
<p>24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 co-pay for Flu and Pneumonia vaccines. 0% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network \$0 co-pay for Flu and Pneumonia vaccines. \$0 co-pay for Hepatitis B vaccine.* No referral needed for Flu and Pneumonia vaccines.</p>
<p>25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>0% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p>In-Network \$0 co-pay for Medicare-covered screening mammograms.*</p>
<p>26 - Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>\$0 co-pay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 0% coinsurance for Pelvic Exams.</p>	<p>In-Network \$0 co-pay for Medicare-covered Pap smears and Pelvic Exams.*</p>
<p>27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>0% coinsurance for the digital rectal exam. \$0 for the PSA test; 0% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network \$0 co-pay for Medicare-covered prostate cancer screening*</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>28 - End-Stage Renal Disease</p>	<p>0% coinsurance for renal dialysis.</p> <p>0% coinsurance for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>In-Network</p> <p>\$0 co-pay for renal dialysis.*</p> <p>\$0 co-pay for Nutrition Therapy for End-Stage Renal Disease.*</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>29 - Prescription Drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>\$0 yearly deductible for Part B-covered drugs.*</p> <p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.wellcare.com on the Web.</p> <p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from WellCare Access (HMO) for certain drugs.</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>29 - Prescription Drugs (Continued)</p>		<p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's Web site, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and WellCare Access (HMO) approves the exception, you will pay Tier 3 cost-sharing for that drug.</p> <p>In-Network</p> <p>You pay a \$0 yearly deductible.</p> <p>Initial Coverage</p> <p>Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 co-pay or • A \$1.10 co-pay or • A \$2.50 co-pay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • A \$0 co-pay or • A \$3.30 co-pay or • A \$6.30 co-pay

BENEFIT**ORIGINAL MEDICARE****WELLCARE ACCESS (HMO)**

29 -
Prescription Drugs
(Continued)

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay a \$0 co-pay.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from WellCare Access (HMO).

Out-of-Network Initial Coverage

Depending on your income and institutional status, you will be reimbursed by WellCare Access (HMO) up to the full cost of the drug minus the following:

For generic drugs purchased out-of-network (including brand drugs treated as generic), either:

- A \$0 co-pay or
- A \$1.10 co-pay or
- A \$2.50 co-pay

For all other drugs purchased out-of-network, either:

- A \$0 co-pay or
- A \$3.30 co-pay or
- A \$6.30 co-pay

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>29 - Prescription Drugs (Continued)</p>		<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network. If you lose eligibility for extra, your Part D prescription drugs costs may be more.</p>
<p>30 - Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>General Authorization rules may apply. In-Network \$0 co-pay for Medicare-covered dental benefits.* \$0 co-pay for up to 1 oral exam(s) every six months. \$0 co-pay for up to 1 cleaning(s) every six months. \$0 co-pay for up to 1 dental X-ray visit(s) every three years.</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>31 - Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered. 0% coinsurance for diagnostic hearing exams.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered diagnostic hearing exams.* 0% of the cost for up to 1 routine hearing test(s) every year. 0% of the cost for up to 1 hearing aid fitting evaluation(s) every three years. \$0 co-pay for up to 1 hearing aid(s) every three years. \$50 limit for routine hearing tests every year. \$350 limit for hearing aids every three years.</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
<p>32 - Vision Services</p>	<p>0% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <p>\$0 co-pay for diagnosis and treatment for diseases and conditions of the eye.*</p> <p>\$0 co-pay for one pair of eyeglasses or contact lenses after cataract surgery.*</p> <p>0% of the cost for up to 1 routine eye exam(s) every year.</p> <p>\$0 co-pay for up to 1 pair(s) of glasses every year.</p> <p>\$0 co-pay for up to 1 pair(s) of contacts every year.</p> <p>\$0 co-pay for up to 1 pair(s) of lenses every year.</p> <p>\$0 co-pay for up to 1 frame(s) every year.</p> <p>\$50 limit for eye exams every year.</p> <p>\$100 limit for contact lenses every year.</p> <p>\$100 limit for eye glass frames every year.</p> <p>Plan offers additional vision benefits.</p>
<p>33 - Physical Exams</p>	<p>0% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network</p> <p>\$0 co-pay for Medicare-covered benefits.*</p> <p>\$0 co-pay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$0 co-pay for Medicare-covered benefits*</p>

BENEFIT	ORIGINAL MEDICARE	WELLCARE ACCESS (HMO)
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	<p>General</p> <p>Authorization rules may apply.</p> <p>Please visit our plan Web site to see our list of covered Over-the-Counter items.</p> <p>OTC items may be purchased only for the enrollee.</p> <p>Please contact the plan for specific instructions for using this benefit.</p> <p>In-Network</p> <p>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Health Club Membership/Fitness Classes • Nursing Hotline • Other Wellness Benefits <p>\$0 co-pay for each Medicare-covered smoking cessation counseling session.*</p>
Transportation (Routine)	Not covered.	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 co-pay for up to 20 one-way trip(s) to plan approved location every year.</p>
Acupuncture	Not covered.	<p>In-Network</p> <p>This plan does not cover Acupuncture.</p>

Medicaid - Summary of Benefits

For Contract H0712 | Plan 005

The services listed below are available only to those SNP members eligible under Medicaid for medical services.

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Important Information</p> <p>Premium and Other Important Information</p>	<p>Medicaid assistance with premium payment may vary based on your level of Medicaid eligibility.</p>	<p>General</p> <p>\$0 to \$34.60 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p>\$0 yearly deductible.*</p> <p>In-Network</p> <p>\$0 yearly deductible.*</p> <p>Out-of-Network</p> <p>\$0 yearly deductible.*</p> <p>In and Out-of-Network</p> <p>\$0 yearly deductible.*</p>
<p>Doctor and Hospital Choice (For more information, see Emergency - and Urgently Needed Care.)</p>	<p>For Dual-eligible Members, Medicaid pays coinsurance, co-payments and deductibles for Medicare covered services. Members should follow Medicare guidelines related to hospital and doctor choice.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network specialists (for certain benefits).</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Inpatient Care</p> <p>Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>\$0 yearly deductible*</p> <p>\$0 co-pay*</p> <p>Plan covers 90 days each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>Inpatient Mental Health Care</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>Same deductible and co-pay as inpatient hospital care (see “Inpatient Hospital Care”)</p> <p>\$0 yearly deductible*</p> <p>\$0 co-pay*</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Skilled Nursing Facility (SNF) (In a Medicare-certified Skilled Nursing Facility)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 yearly deductible.*</p> <p>\$0 co-pay for SNF services.*</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>For non-Medicare-covered SNF stays:</p> <ul style="list-style-type: none"> • Days 1 - 20: \$0 per day • Days 21 - 100: \$0 per day <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p>
<p>Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 co-pay for Medicare-covered home health visits.*</p>
<p>Hospice</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>You must get care from a Medicare-certified hospice.</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Outpatient Care</p> <p>Doctor Office Visits</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>See “Physical Exams,” for more information.</p> <p>In-Network</p> <p>\$0 co-pay for each primary care doctor visit for Medicare-covered benefits.*</p> <p>\$0 co-pay for the cost of each in-area, network urgent care Medicare-covered visit.*</p> <p>\$0 co-pay for each specialist doctor visit for Medicare-covered benefits.*</p>
<p>Chiropractic Services</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>\$0 co-pay for Medicare-covered chiropractic visits.*</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
<p>Podiatry Services</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>\$0 co-pay for Medicare-covered podiatry benefits.*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<p>Outpatient Mental Health Care</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>\$0 co-pay for Medicare-covered Mental Health visits.*</p> <p>\$0 co-pay for each Medicare-covered visit with a psychiatrist.*</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
Outpatient Substance Abuse Care	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Medicare-covered visits.*
Outpatient Services/Surgery	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	General Authorization rules may apply. In-Network \$0 co-pay for each Medicare-covered ambulatory surgical center visit.* \$0 co-pay for each Medicare-covered outpatient hospital facility visit.*
Ambulance Services (medically necessary ambulance services)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Medicare-covered ambulance benefits.*
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	General \$0 co-pay for Medicare-covered emergency room visits.* Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General \$0 co-pay for Medicare-covered urgent-care visits.* If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.</p>
<p>Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered Occupational Therapy visits.* \$0 co-pay for Medicare-covered Physical and/or Speech/Language Therapy visits.*</p>
<p>Outpatient Medical Services and Supplies</p> <p>Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered items.*</p>
<p>Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered items.*</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Diabetes self-monitoring training.* \$0 co-pay for Nutrition Therapy for Diabetes.* \$0 co-pay for Diabetes supplies.*</p>
<p>Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services* • diagnostic procedures and tests* • X-rays* • diagnostic radiology services (not including X-rays)* • therapeutic radiology services*
<p>Preventive Services</p> <p>Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.</p>	<p>In-Network \$0 co-pay for Medicare-covered bone mass measurement.*</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
Colorectal Screening Exams (for people with Medicare age 50 and older)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Medicare-covered colorectal screenings.*
Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Flu and Pneumonia vaccines. \$0 co-pay for Hepatitis B vaccine.* No referral needed for Flu and Pneumonia vaccines.
Mammograms (Annual Screening) (for women with Medicare age 40 and older)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Medicare-covered screening mammograms.*
Pap Smears and Pelvic Exams (for women with Medicare)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Medicare-covered Pap smears and Pelvic Exams.*
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	For Dual-eligible Members, Medicaid managed care pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for Medicare-covered prostate cancer screening.*
End-Stage Renal Disease	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 co-pay for Medicaid-covered services.	In-Network \$0 co-pay for renal dialysis.* \$0 co-pay for Nutrition Therapy for End-Stage Renal Disease.*

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Prescription Drugs</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>\$0 yearly deductible for Part B-covered drugs.*</p> <p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.wellcare.com on the Web.</p> <p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from WellCare Access (HMO) for certain drugs.</p>

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO)**

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and WellCare Access (HMO) approves the exception, you will pay Tier 3 cost-sharing for that drug.

In-Network

You pay a \$0 yearly deductible.

Initial Coverage

Depending on your income and institutional status, you pay the following:

For generic drugs (including brand drugs treated as generic), either:

- A \$0 co-pay or
- A \$1.10 co-pay or
- A \$2.50 co-pay

For all other drugs, either:

- A \$0 co-pay or
- A \$3.30 co-pay or
- A \$6.30 co-pay

BENEFIT**MEDICAID****WELLCARE ACCESS (HMO)****Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach \$4,550, you pay a \$0 co-pay.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from WellCare Access (HMO).

Out-of-Network Initial Coverage

Depending on your income and institutional status, you will be reimbursed by WellCare Access (HMO) up to the full cost of the drug minus the following:

For generic drugs purchased out-of-network (including brand drugs treated as generic), either:

- A \$0 co-pay or
- A \$1.10 co-pay or
- A \$2.50 co-pay

For all other drugs purchased out-of-network, either:

- A \$0 co-pay or
- A \$3.30 co-pay or
- A \$6.30 co-pay

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
		<p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network.</p> <p>If you lose eligibility for extra help, your Part D prescription drugs costs may be more.</p>
<p>Dental Services</p>	<p>The following Dental Services are a benefit of Connecticut Medicaid.</p> <p>Services covered are preventive, restorative, oral surgery and orthodontics. Medicaid covered dental services including necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.</p> <p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 co-pay for Medicare-covered dental benefits.*</p> <p>\$0 co-pay for up to 1 oral exam(s) every six months.</p> <p>\$0 co-pay for up to 1 cleaning(s) every six months.</p> <p>\$0 co-pay for up to 1 dental x-ray visit(s) every three years.</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Hearing Services</p>	<p>The following Hearing Services are a benefit of Connecticut Medicaid.</p> <p>Hearing services and products when medically necessary to alleviate disability caused by loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aids, ear molds, special fittings and replacement parts.</p> <p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered diagnostic hearing exams.*</p> <p>0% of the cost for up to 1 routine hearing test(s) every year.</p> <p>0% of the cost for up to 1 hearing aid fitting evaluation(s) every three years.</p> <p>\$0 copay for up to 1 hearing aid(s) every three years.</p> <p>\$50 limit for routine hearing tests every year.</p> <p>\$350 limit for hearing aids every three years.</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Vision Services</p>	<p>The following Vision Services are a benefit of Connecticut Medicaid.</p> <p>Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage includes the replacement of lost or destroyed glasses and the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to once per year unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than one (1) pair, once per year unless medically necessary or unless the glasses are lost, damaged or destroyed. No prerequisite of cataract services.</p> <p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>\$0 co-pay for diagnosis and treatment for diseases and conditions of the eye.*</p> <p>\$0 co-pay for one pair of eyeglasses or contact lenses after cataract surgery.*</p> <p>0% of the cost for up to 1 routine eye exam(s) every year.</p> <p>\$0 co-pay for up to 1 pair(s) of glasses every year.</p> <p>\$0 co-pay for up to 1 pair(s) of contacts every year.</p> <p>\$0 co-pay for up to 1 pair(s) of lenses every year.</p> <p>\$0 co-pay for up to 1 frame(s) every year.</p> <p>\$50 limit for eye exams every year.</p> <p>\$100 limit for contact lenses every year.</p> <p>\$100 limit for eye glass frames every year.</p> <p>Plan offers additional vision benefits.</p>
<p>Physical Exams</p>	<p>For Dual-eligible Members, Medicaid managed care pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>In-Network</p> <p>\$0 co-pay for Medicare-covered benefits.*</p> <p>\$0 co-pay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$0 co-pay for Medicare-covered benefits.*</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Health/Wellness Education</p>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>Please visit our plan Web site to see our list of covered Over-the-Counter items.</p> <p>OTC items may be purchased only for the enrollee.</p> <p>Please contact the plan for specific instructions for using this benefit.</p> <p>In-Network</p> <p>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Health Club Membership/Fitness Classes • Nursing Hotline • Other Wellness Benefits <p>\$0 co-pay for each Medicare-covered smoking cessation counseling session.*</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
<p>Transportation (Routine)</p>	<p>The following Transportation Services are a benefit of Connecticut Medicaid.</p> <p>Transportation essential for an enrollee to obtain necessary medical care services. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee's medical condition. Mileage reimbursement for family members driving to an appointment. This benefit is available only in certain circumstances if no other means of transportation is available.</p> <p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for up to 20 one-way trip(s) to plan-approved locations every year.</p>
<p>Acupuncture</p>	<p>Not covered</p>	<p>This plan does not cover Acupuncture.</p>
<p>Family Planning</p>	<p>The following Family Planning Services are a benefit of Connecticut Medicaid.</p> <p>The department shall pay for family planning that may include: Abortion and hysterectomy services; Early and Periodic Screening; Diagnostic and Treatment services; Family planning services for clients of childbearing age</p> <p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>WellCare Access (HMO) does not cover Family Planning Services.</p> <p>Please use your state issued Medicaid Card to access services.</p>

BENEFIT	MEDICAID	WELLCARE ACCESS (HMO)
Natureopath	<p>The following Natureopath Services are a benefit of Connecticut Medicaid.</p> <p>The department shall pay for the professional services of a licensed natureopath which conform to accepted methods of diagnosis and treatment.</p> <p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>WellCare Access (HMO) does not cover Natureopath Services.</p> <p>Please use your state issued Medicaid Card to access services.</p>
Targeted Case Management	<p>The following Targeted Case Management Services are a benefit of Connecticut Medicaid.</p> <p>Case management services may include a continuum of supportive activities performed by an individual case manager which enable an eligible person to gain access to needed services. Case management services can include one or more of the following types of case management activities in a calendar quarter:</p> <p>Case advocacy, Collaboration, Coordinating or attending team meetings, Coordination of a plan of services, Monitoring the quality and quantity, Providing information and referral & Review and maintenance of an eligible person's plan of services.</p> <p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 co-pay for Medicaid-covered services.</p>	<p>WellCare Access (HMO) does not cover Targeted Case Management Services.</p> <p>Please use your state issued Medicaid Card to access services.</p>

WellCare is a health plan with a Medicare contract that is renewed annually, and the availability of coverage beyond the end of the current contract year is not guaranteed. Benefits and limitations may vary by plan and by county. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

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