2022
Summary of Benefits

New York

Wellcare Dual Access (HMO D-SNP)

H4868 | 014

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

This is a summary of drug and health services covered by Wellcare Dual Access (HMO D-SNP) from January 1, 2022 to December 31, 2022.

This booklet will provide you with a summary of what we cover and the cost-sharing responsibilities. It does not list every service, limitation, or exclusion. A complete list of services can be found in the plan's Evidence of Coverage (EOC). You can find the Evidence of Coverage on our website at www.wellcare.com/medicare. Or, you may call us to ask for a copy at the phone number listed on the back cover.

Who can join?

To enroll in one of our plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

Our service area includes these counties in New York: Bronx, Kings, Nassau, New York, Queens, and Richmond.

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

You must also be enrolled in the New York Medicaid plan. Premiums, copayments, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive. Your Part B premium is paid by the State of New York for full-dual enrollees. Please contact the plan for further details.

Understanding Dual Eligibility

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid benefits are valuable because the state provides additional healthcare coverage and financial support based on your Medicare Savings Program (MSP) aid level. Medicaid coverage varies depending on the state and the type of Medicaid you have. What you pay for covered services may depend on your level of Medicaid eligibility. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people may also get coverage for additional services and drugs that are covered under Medicaid but not by Medicare.

Dual Eligible Special Needs Plan (DSNPs) are specialized Medicare Advantage plans that provide healthcare benefits for beneficiaries that have both Medicare and Medicaid coverage. Beneficiaries must meet certain income and resource requirements with eligibility and scope of benefits offered determined by the state where the plan is offered.

Medicare Savings Program (MSP) Levels

- ***Full-Benefit Dual Eligible (FBDE):*** Medicaid may pay for your Medicare Part A & B premiums, deductibles, coinsurances, and copayments. Eligible beneficiaries also receive full Medicaid

benefits.

- ***Qualified Medicare Beneficiary (QMB):*** Medicaid will pay for your Medicare Part A & B premiums, deductibles, coinsurances, and copayments. (Some people with QMB are also eligible for full Medicaid benefits (QMB+))
- ***Specified Low-Income Medicare Beneficiary (SLMB):*** Medicaid will absorb the cost of your Medicare Part B Premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+)
- ***Qualified Individual (QI):*** Medicaid will pay costs associated with Medicare Part B
- ***Qualified Disabled Working Individual (QDWI):*** Medicaid will pay costs associated with Medicare Part A

Note: Some MSP levels automatically qualify for "Extra Help" for Medicare prescription drug coverage assistance. Some states do not cover Parts A & B cost sharing.

What is "Extra Help?"

A Low Income Subsidy (LIS), also referred to as "Extra Help," may be available to help you with Part D out-of-pocket expenses such as premiums, deductibles, coinsurance, or copayments. Many people qualify for the "Extra Help" Program and don't even know it. Keep in mind that assistance may also depend on your Medicare Savings Program (MSP) level and your dual eligible status.

If you have questions about your Medicaid eligibility and what benefits you are entitled to, call the number listed on the back cover of this document.

This plan is available to anyone who has both Medical Assistance from the State and Medicare

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

Our plans give you access to our network of highly skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. You can ask for a current provider and pharmacy directory or, for an up-to-date list of network providers, visit www.wellcare.com/medicare. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor our plan will be responsible for the costs.)

Our plans also include prescription drug coverage and access to our large network of pharmacies. Our plans use a formulary. Our drug plans are designed specifically for Medicare beneficiaries and include a comprehensive selection of affordable generic and brand name drugs.

Which doctors, hospitals and pharmacies can I use? Wellcare Dual Access (HMO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers. You can save money by using our preferred mail-order

pharmacy and by using providers in the plan's network. With some plans if you use providers that are not in our network, your share of the costs for covered services may be higher.

You can see our plan's provider and pharmacy directory and for plans with prescription drug coverage, our complete plan Formulary (list of Part D prescription drugs) on our website at www.wellcare.com/medicare.

For more information, please call us at 1-844-917-0175 (TTY users should call 711). Hours are Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. Visit us at www.wellcare.com/medicare.

We must provide information in a way that works for you (in languages other than English, in audio, in braille, in large print, or other alternate formats, etc.). Please call member services if you need plan information in another format.

Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Service Area	Our service area includes these counties in New York: Bronx, Kings, Nassau, New York, Queens, and Richmond.
Special Needs Plans Eligibility Criteria	This plan includes (FBDE, QMB, QMB+, SLMB+). Refer to "Medicare Savings Program (MSP) Levels" at the beginning of this document
Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive	
Monthly plan premium You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.	$0
Deductible	No deductible
Maximum out-of-Pocket Responsibility (does not include prescription drugs)	$3,450 annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.
Inpatient Hospital coverage	Days 1-90: $0 copay per stay *
Outpatient Hospital coverage Outpatient hospital services	$0 copay for surgical and non-surgical services *
Outpatient hospital observation services	$0 copay *

Services with an asterisk (*) may require prior authorization.
Services with a square (▪) means a referral may be required.

Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Ambulatory surgical center (ASC)	$0 copay *
Doctor Visits Primary Care Providers	 $0 copay
Specialists	$0 copay *
Preventive Care (e.g., Annual Wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular screenings, Cervical and vaginal cancer screening, Colorectal cancer screenings, Diabetes screenings, Hepatitis B Virus Screening, Prostate cancer screenings (PSA), Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots))	$0 copay
Emergency care	$0 copay
Worldwide emergency coverage	$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.
Urgently needed services	$0 copay

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Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Worldwide urgent care coverage	$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.
Diagnostic Services/Labs/Imaging	COVID-19 testing and specified testing-related services at any location are $0.
Lab services	$0 copay *
Diagnostic tests and procedures	$0 copay *
Outpatient X-rays	$0 copay *
Diagnostic radiology services (e.g. MRI, CAT Scan)	$0 copay *
Therapeutic Radiology	$0 copay *
Hearing services Hearing Exam Medicare Covered	$0 copay *
Routine hearing exam	$0 copay * 1 exam every year

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Benefits

	Wellcare Dual Access (HMO D-SNP) H4868, Plan 014
Hearing Aids	
Hearing Aid Fitting/Evaluation(s)	$0 copay * 1 fitting(s) / evaluation(s) every year
Hearing aid allowance	Up to a $1,500 allowance for both ears combined every year for hearing aids.
All types	$0 copay * Limited to 2 hearing aid(s) every year
Additional Hearing Information	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.
Dental services	
Preventive services	$0 copay * Cleanings 2 every year Dental x-rays 1 every 12 to 36 months Oral exams 2 every year
Fluoride Treatment	$0 copay * 1 every year
Comprehensive services	
Medicare Covered	$0 copay for each Medicare-covered service *

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Benefits

	Wellcare Dual Access (HMO D-SNP) H4868, Plan 014
Diagnostic Services	$0 copay * 1 diagnostic service(s) every year
Restorative Services	$0 copay * 1 restorative service(s) every 12 to 84 months
Endodontics/ Periodontics/ Extractions	$0 copay * 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months 1 extraction(s) per tooth
Non-routine services	$0 copay * 1 non-routine service(s) every day to 60 months
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	$0 copay * 1 Prosthodontic procedure every 12 to 84 months 1 Oral Maxillofacial procedure every 12 to 60 months or per lifetime 1 Other service every 6 to 60 months
Additional Dental Information	**What you should know:** This plan includes coverage of preventive and comprehensive services up to $3,000.
Vision Services	
Eye Exam Medicare Covered	$0 copay (Medicare-covered diabetic retinopathy screening) $0 copay (all other Medicare-covered eye exams) *

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Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Routine eye exam (Refraction)	$0 copay * 1 exam every year
Glaucoma screening	$0 copay for each Medicare-covered service.
Eyewear Medicare Covered	$0 copay *
Routine eyewear Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames Eyewear allowance	 $0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year * Up to a $100 combined allowance every year.
Mental Health Services Inpatient visit	 Days 1-90: $0 copay per day *
Outpatient individual therapy visit	$0 copay *
Outpatient group therapy visit	$0 copay *
Skilled nursing facility (SNF)	Days 1-100: $0 copay per benefit period. *

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Benefits

	Wellcare Dual Access (HMO D-SNP) H4868, Plan 014
Therapy and Rehabilitation Services Physical Therapy	$0 copay *
Outpatient rehabilitation services provided by an occupational therapist	$0 copay *
Pulmonary rehabilitation services	$0 copay *
Ambulance Ground Ambulance	$0 copay *
Air Ambulance	$0 copay *
Transportation Services	Up to 24 one-way trips every year to plan-approved health-related locations. Mileage limits may apply. $0 copay (per one-way trip) * **What you should know:** The first step to staying healthy is getting to your doctor. That's why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need, when you need it. Call Customer Service 72 hours in advance to reserve a ride for your appointment. Mileage limitations may apply.
Medicare Part B Drugs Chemotherapy drugs	$0 copay *

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	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Other Part B drugs	$0 copay *

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Prescription Drug Coverage	**Wellcare Dual Access (HMO D-SNP)** **H4868, Plan 014**
Stage 1: Annual Prescription Deductible	
Deductible	This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.
Stage 2: Initial Coverage (after you pay your deductible, if applicable)	
You pay the following until your total yearly drug costs reach $4,230. The cost share you pay depends on your level of "Extra Help". Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.	
Standard Retail cost-sharing (30-day/90-day supply)	
	Standard
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 4 (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%

Prescription Drug Coverage	Wellcare Dual Access (HMO D-SNP) H4868, Plan 014
	Standard
Tier 5 (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15% Limited to 30 day supply
Tier 6 (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%

Prescription Drug Coverage	Wellcare Dual Access (HMO D-SNP) H4868, Plan 014	
Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)		
Mail-order cost-sharing (30-day/90-day supply)		
	Preferred	**Standard**
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 copay	$0 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 4 (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 5 (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15% Limited to 30 day supply	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15% Limited to 30 day supply

Prescription Drug Coverage	Wellcare Dual Access (HMO D-SNP) H4868, Plan 014	
	Preferred	**Standard**
Tier 6 (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Stage 3: Coverage Gap		
	After your total drug costs (including what our plan has paid and what you have paid) reach $4,230, you will pay your "Extra Help" cost share or no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.	
Stage 4: Catastrophic Coverage		
	After your yearly out-of-pocket drug costs (not including what the plan has paid, but including drugs you purchased through your retail pharmacy and through mail order) reach $7,050, depending on your level of “Extra Help” you pay nothing or: • $3.95 copay for generics (including brand drugs treated as generic), or • $9.85 copay for all other drugs	

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (30-day supply) or long term (90-day supply).

Excluded Drugs:

This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil and Vardenafil on Tier 1 have a quantity limit of six pills every 30 days.

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

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

Additional Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Chiropractic Services Medicare-covered	$0 copay *
Routine chiropractic services	$0 copay * Unlimited visits every year
Acupuncture Medicare-covered	$0 copay *
Routine acupuncture services	$0 copay Limited to 24 visit(s) every year.
Podiatry Services (Foot Care) Medicare Covered	$0 copay * **What you should know:** Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.
Virtual Visits	Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors via Teladoc to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more. A virtual visit (also known as a telehealth consult) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.

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Additional Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Home health agency care	$0 copay *
Meals Post-Acute Meals	$0 copay for each post-acute meal ▪ **What you should know:** You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days.
Chronic Meals	$0 copay for each chronic meal ▪ **What you should know:** You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modifications. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months.
Medical Equipment/Supplies Durable Medical Equipment (DME)	$0 copay *
Prosthetics	$0 copay *
Diabetic supplies	$0 copay *
Diabetic therapeutic shoes or inserts	$0 copay *
Opioid treatment program services	$0 copay *

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Additional Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
Over-the-Counter (OTC) Items	$0 copay The maximum total benefit is $155 every month **What you should know:** Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.
Wellness Programs Fitness	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. $0 copay Coverage includes: Activity Tracker and Physical Fitness **What you should know:** This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.
Additional sessions of smoking and tobacco cessation counseling	$0 copay Limited to 5 visit(s) every year
24-Hour Nurse Advice Line	$0 copay
Personal emergency medical response device (PERS)	$0 copay
Special Supplemental Benefits for Chronically Ill (SSBCI) To qualify for these benefits you must meet specific criteria, including having a qualifying chronic condition and determined to be eligible for high-risk care	Grocery Delivery: You pay $0 copay Plan covers up to $50 per month to use on plan-approved grocery items. Limitations apply. Referral may be required *

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Additional Benefits

	Wellcare Dual Access (HMO D-SNP) **H4868, Plan 014**
management. For a complete list of eligibility criteria, please see the Evidence of Coverage.	
Flex Card	$1,500 yearly benefit **What you should know:** The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier.
In-home support services	$0 copay for each in-home support services visit. Up to 6 visits every year. **What you should know:** You can receive Chore Services if you meet certain clinical criteria. Services must be recommended or requested by a licensed plan clinician or a license plan provider. Services are provided in two hour increments.

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Comprehensive Written Statement for Prospective Enrollees

The benefits described in the Premium and Benefit section of the Summary of Benefits are covered by our Wellcare Dual Access (HMO D-SNP). For each benefit listed, you can see what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. Coverage of the benefits described in this Summary of Benefits depends upon your level of Medicaid eligibility. No matter what your level of Medicaid eligibility is, Wellcare Dual Access (HMO D-SNP) will cover the benefits described in the Premium and Benefit section of the Summary of Benefits. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call New York Medicaid toll-free at 1-800-541-2831 (TTY: 711).

Our source of information for Medicaid benefits is https://www.health.ny.gov/health_care/medicaid/. All Medicaid covered services are subject to change at any time. For the most current New York Medicaid coverage information, please visit https://www.health.ny.gov/health_care/medicaid/ or call member services for assistance. A detailed explanation of New York Medicaid benefits can be found in the New York Summary of Services online at https://www.health.ny.gov/health_care/medicaid/.

Benefit Category	New York Medicaid
Inpatient Mental Health Over 190-Day Lifetime Limit	All inpatient mental health services, including voluntary or involuntary admissions for mental health services, over the Medicare 190-Day Lifetime Limit. The Contractor may provide the covered benefit for medically necessary mental health impatient services through hospitals licensed pursuant to Article 28 of the New York State P.H.L. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Non-Medicare Covered Care in Skilled Nursing Facility	Skilled nursing facility days provided by a licensed facility as specified in Chapter V, 10 NYCRR, in excess of the first 100 days in the Medicare Advantage benefit period. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Non-Medicare Covered Home Health Services	Medicaid covered home health services include the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and /or home health aide services as required by an approved plan of care. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

Benefit Category	New York Medicaid
Non-Medicare Covered Durable Medical Equipment	Medicare and Medicaid covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Personal Care Services	Personal care services (“PCS”) are the provision of some or total assistance with such activities as personal hygiene, dressing and feeding; and nutritional and environmental support function tasks (meal preparation and housekeeping). Such services must be essential to the maintenance of the Member’s health and safety in his or her own home. Personal care must be medically necessary, ordered by the Member’s physician and provided by a qualified person as defined in Part 700.2(b)(14) of 10 NYCRR, in accordance with a plan of care. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Dental Services	Dental services include, but shall not be limited to, preventive, prophylactic and other dental care, services, supplies, routine exams, prophylaxis, oral surgery (when not covered by Medicare), and dental prosthetic and orthotic appliances required to alleviate a serious health condition, including one which affects employability. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

Benefit Category	New York Medicaid
Non-Emergency Transportation	Transportation expenses are covered when transportation is essential in order for a Member to obtain necessary medical care and services which are covered under the Medicaid program. Transportation services means transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Member's medical condition; and a transportation attendant to accompany the Member, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the Member's family. Depending on level of Medicaid eligibility, $0 copay for Medicaid services. For Members with disabilities, the method of transportation must reasonablyaccommodate their needs, taking into account the severityand nature of the disability.

Benefit Category	New York Medicaid
Medical and Surgical Supplies, Enteral and Parenteral Formula and Hearing Aid Batteries	These items are generally considered to be one-time only use, consumable items routinely paid for under the Durable Medical Equipment category of fee-for–service Medicaid. Coverage of enteral formula and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding. Coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; and, 3) children who require medical formulas due to mitigating factors in growth and development. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

Benefit Category	New York Medicaid
Nutrition	Nutrition services includes the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within the patient's home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, provision of in-service education to health agency staff as well as consultation on specific dietary problems of patients and nutrition teaching to patients and families. These services must be provided by a qualified nutritionist as defined in Part 700.2(b)(5), 10 NYCRR. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Medical Social Services	Medical social services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a plan of care. These services must be provided by a qualified social worker as defined in Section 700.2(b)(24) 10 NYCRR. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Social and Environmental Supports	Social and environmental supports are services and items that support the medical needs of the Members and are included in a Member's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

Benefit Category	New York Medicaid
Adult Day Health Care	Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Social Day Care	Social day care is a structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24 hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, care giver assistance and case coordination and assistance. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Personal Emergency Response Services	Personal Emergency Response Services (“PERS”) is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a patient’s phone and signal a response center once a “help” button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

Benefit Category	New York Medicaid
Hearing Services	Hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

Benefit Category	New York Medicaid
Vision Services	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 also includes 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 every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed. If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered. Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Medicaid Pharmacy Benefits	as allowed by State Law (select drug categories excluded from the Medicare Part D benefit). Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

Benefit Category	New York Medicaid
Methadone Maintenance Treatment Programs	Medicaid coverage provided Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Certain Mental Health Services	Medicaid coverage includes: Intensive Psychiatric Rehabilitation Treatment Programs Day Treatment Continuing Day Treatment Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units) Partial Hospitalizations Assertive Community Treatment (ACT) Personalized Recovery Oriented Services (PROS) Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Office for People with Developmental Disabilities (OPWDD) Services	Medicaid coverage provided Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Comprehensive Medicaid Case Management	Medicaid coverage provided Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Home and Community Based Waiver Program Services	Medicaid coverage provided Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Directly Observed Therapy for Tuberculosis Disease	Medicaid coverage provided Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
AIDS Adult Day Health Care	Medicaid coverage provided Depending on level of Medicaid eligibility, $0 copay for Medicaid services.
Assisted Living Program	Medicaid coverage provided Depending on level of Medicaid eligibility, $0 copay for Medicaid services.

ATENCIÓN: Si habla español, contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. Llame al 1-877-374-4056 (TTY: 711).

注意：如果您説中文，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 quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí dành cho quý vị. Hãy gọi số 1-877-374-4056 (TTY: 711).

주의사항: 한국어를 구사할 경우, 언어 보조 서비스를 무료로 이용 가능합니다. 1-877-374-4056 (TTY: 711) 번으로 연락해 주십시오.

Atensyon: Kung nagsasalita ka ng Tagalog, may mga available na libreng tulong sa wika para sa iyo. Tumawag sa 1-877-374-4056 (TTY: 711).

Dumngeg: No agsasau ka iti Ilokano, dagiti tulong nga serbisio, a libre, ket available para kaniam. Awagan ti 1-877-374-4056 (TTY: 711).

La Silafia: Afai e te tautala i le gagana Sāmoa, gagana ‘au’aunaga fesoasoani, fai fua leai se totogi, o lo’o avanoa ia te ‘oe. Vala’au le 1-877-374-4056 (TTY: 711).

Maliu: Inā ‘ōlelo Hawai‘i ‘oe, he lawelawe māhele ‘ōlelo, manuahi, i lako iā ‘oe. E kelepona iā 1-877-374-4056 (TTY: 711).

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-917-0175 (TTY: 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Visit www.wellcare.com/medicare or call 1-844-917-0175 (TTY: 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ **For plans with a plan premium (Does not apply to plans with zero plan premium):** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- ☐ **For HMO plans only:** Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **For PPO and PFFS plans only:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ **For C-SNP plans only:** This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- ☐ **For D-SNP plans only:** This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Contact Us

For more information, please contact us:

By phone

Toll-free at 1-844-917-0175 (TTY 711). Your call may be answered by a licensed agent.

Hours of Operation

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

Online www.wellcare.com/medicare

We're with our members every step of the way.

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