



**January 1 – December 31, 2026**

## **Evidence of Coverage for 2026:**

### **Your Medicare Health Benefits and Services and Drug coverage as a Member of Wellcare 'Ohana Dual Align (HMO-POS D-SNP)**

This document gives the details about your Medicare and Hawaii Med-QUEST Division Program (Medicaid) health and drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

**For questions about this document, call Member Services at 1-888-846-4262. (TTY users call 711). Hours are: Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m. This call is free.**

This plan, Wellcare 'Ohana Dual Align (HMO-POS D-SNP), is offered by Wellcare Health Insurance Of Arizona, Inc. (Wellcare By 'Ohana Health Plan) (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Wellcare Health Insurance Of Arizona, Inc. (Wellcare By 'Ohana Health Plan) When it says “plan” or “our plan,” it means Wellcare 'Ohana Dual Align (HMO-POS D-SNP).)

This document is available for free in Chinese, Korean, Hmong, Tagalog, Laotian, Cambodian/Khmer, Vietnamese, Hawaiiin, Japanese, Karen, Samoan, Thai, Turkish, Uzbek, Ilocano, and Burmese. We must provide information in a way that works for you (in languages other than English, in braille, in audio, in large print, or other alternate formats, etc.). Please call Member Services if you need plan information in another format.

Benefits and/or copayments/coinsurance may change on January 1, 2027.

OMB Approval 0938-1051  
(Expires: August 31, 2026)  
4609066\_HI6ZSPEOCENG\_M\_0001  
H9916001000



Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

Based on a Model of Care review, Wellcare 'Ohana Dual Align (HMO-POS D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2028.



**Table of Contents****Table of Contents**

<b>CHAPTER 1: Get started as a member.....</b>	<b>5</b>
SECTION 1 You're a member of Wellcare 'Ohana Dual Align (HMO-POS D-SNP).....	5
SECTION 2 Plan eligibility requirements .....	6
SECTION 3 Important membership materials .....	8
SECTION 4 Summary of Important Costs for 2026.....	10
SECTION 5 More information about your monthly plan premium .....	14
SECTION 6 Keep our plan membership record up to date .....	14
SECTION 7 How other insurance works with our plan.....	15
<b>CHAPTER 2: Phone numbers and resources .....</b>	<b>17</b>
SECTION 1 Our plan contacts.....	17
SECTION 2 Get help from Medicare .....	22
SECTION 3 State Health Insurance Assistance Program (SHIP) .....	23
SECTION 4 Quality Improvement Organization (QIO) .....	24
SECTION 5 Social Security.....	25
SECTION 6 Medicaid .....	26
SECTION 7 Programs to help people pay for prescription drugs .....	27
SECTION 8 Railroad Retirement Board (RRB) .....	30
SECTION 9 If you have group insurance or other health insurance from an employer .....	30
<b>CHAPTER 3: Using our plan for your medical and other covered services .....</b>	<b>31</b>
SECTION 1 How to get medical care and other services as a member of our plan .....	31
SECTION 2 Use providers in our plan's network to get medical care and other services.....	33
SECTION 3 How to get services in an emergency, disaster, or urgent need for care .....	37
SECTION 4 What if you're billed directly for the full cost of covered services? .....	39
SECTION 5 Medical services in a clinical research study .....	40
SECTION 6 Rules for getting care in a religious non-medical health care institution.....	41



## Table of Contents

---

SECTION 7	Rules for ownership of durable medical equipment.....	42
<b>CHAPTER 4: Medical Benefits Chart (what's covered)</b>		<b>45</b>
SECTION 1	Understanding covered services.....	45
SECTION 2	The Medical Benefits Chart shows your medical benefits and costs .....	46
SECTION 3	Services covered outside of <i>the plan</i> .....	103
SECTION 4	Services that aren't covered by our plan (exclusions) .....	104
<b>CHAPTER 5: Using plan coverage for Part D drugs</b>		<b>107</b>
SECTION 1	Basic rules for our plan's Part D drug coverage .....	107
SECTION 2	Fill your prescription at a network pharmacy or through our plan's mail-order service.....	108
SECTION 3	Your drugs need to be on our plan's Drug List .....	112
SECTION 4	Drugs with restrictions on coverage .....	114
SECTION 5	What you can do if one of your drugs isn't covered the way you'd like .....	115
SECTION 6	Our Drug List can change during the year .....	117
SECTION 7	Types of drugs we don't cover .....	119
SECTION 8	How to fill a prescription .....	120
SECTION 9	Part D drug coverage in special situations .....	120
SECTION 10	Programs on drug safety and managing medications.....	121
SECTION 11	Your <i>Part D Explanation of Benefits</i> explains which payment stage you're in .....	123
<b>CHAPTER 6: What you pay for Part D drugs</b>		<b>126</b>
<b>CHAPTER 7: Asking us to pay a bill for covered medical services or drugs</b>		<b>127</b>
SECTION 1	Situations when you should ask us to pay our share for covered services or drugs .	127
SECTION 2	How to ask us to pay you back or pay a bill you got .....	130
SECTION 3	We'll consider your request for payment and say yes or no .....	131
<b>CHAPTER 8: Your rights and responsibilities</b>		<b>132</b>



## Table of Contents

---

SECTION 1	Our plan must honor your rights and cultural sensitivities .....	132
SECTION 2	Your responsibilities as a member of our plan .....	153
<b>CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints) .....</b>		<b>154</b>
SECTION 1	What to do if you have a problem or concern .....	154
SECTION 2	Where to get more information and personalized help .....	154
SECTION 3	Understanding Medicare and Hawaii Med-QUEST Division Program (Medicaid) complaints and appeals .....	155
SECTION 4	Which process to use for your problem .....	156
SECTION 5	A guide to coverage decisions and appeals.....	156
SECTION 6	Medical care: How to ask for a coverage decision or make an appeal .....	159
SECTION 7	Part D drugs: How to ask for a coverage decision or make an appeal .....	168
SECTION 8	How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon .....	176
SECTION 9	How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	181
SECTION 10	Taking your appeal to Levels 3, 4 and 5 .....	184
SECTION 11	How to make a complaint about quality of care, waiting times, customer service, or other concerns .....	187
<b>CHAPTER 10: Ending membership in our plan .....</b>		<b>192</b>
SECTION 1	Ending your membership in our plan .....	192
SECTION 2	When can you end your membership in our plan?.....	192
SECTION 3	How to end your membership in our plan.....	195
SECTION 4	Until your membership ends, you must keep getting your medical items, services and drugs through our plan .....	196
SECTION 5	Wellcare 'Ohana Dual Align (HMO-POS D-SNP) must end our plan membership in certain situations .....	197
<b>CHAPTER 11: Legal notices.....</b>		<b>199</b>
SECTION 1	Notice about governing law .....	199



Table of Contents

---

SECTION 2	Notice about nondiscrimination .....	199
SECTION 3	Notice about Medicare Secondary Payer subrogation rights.....	199
SECTION 4	Recovery of benefits paid by our plan under your Wellcare 'Ohana Dual Align (HMO-POS D-SNP) plan.....	200
SECTION 5	Membership card .....	202
SECTION 6	Independent contractors .....	202
SECTION 7	Health care plan fraud .....	202
SECTION 8	Circumstances beyond the plan’s control .....	203
<b>CHAPTER 12: Definitions.....</b>		<b>204</b>



# CHAPTER 1:

## Get started as a member

### SECTION 1 You're a member of Wellcare 'Ohana Dual Align (HMO-POS D-SNP)

---

#### Section 1.1 You're enrolled in Wellcare 'Ohana Dual Align (HMO-POS D-SNP), which is a Medicare Special Needs Plan

You're covered by both Medicare and Hawaii Med-QUEST Division Program (Medicaid):

- **Medicare** is the federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that aren't covered by Medicare.

You've chosen to get your Medicare and Hawaii Med-QUEST Division Program (Medicaid) health care and your drug coverage through our plan, Wellcare 'Ohana Dual Align (HMO-POS D-SNP). Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

Wellcare 'Ohana Dual Align (HMO-POS D-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. Wellcare 'Ohana Dual Align (HMO-POS D-SNP) is designed for people who have Medicare and are entitled to help from Hawaii Med-QUEST Division Program (Medicaid).

Because you get help from Hawaii Med-QUEST Division Program (Medicaid) with Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Hawaii Med-QUEST Division Program (Medicaid) may also provide other benefits by covering health care services that aren't usually covered under Medicare. You'll also get Extra Help from Medicare to pay for the costs of your Medicare drugs. Our plan will help you manage all these benefits, so you get the health services and payment help that you're entitled to.

Our plan is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. Our plan also has a contract with the Hawaii Medicaid Program to



## Chapter 1 Get started as a member

---

coordinate your Hawaii Med-QUEST Division Program (Medicaid) benefits. We're pleased to provide your Medicare and Hawaii Med-QUEST Division Program (Medicaid) coverage, including drug coverage.

### Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in our plan between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of our plan after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) and Hawaii Med-QUEST Division Program (Medicaid) must approve our plan. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare and Hawaii Med-QUEST Division Program (Medicaid) renews approval of our plan.

## SECTION 2 Plan eligibility requirements

---

### Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.
- You meet the special eligibility requirements described below.

#### Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who get certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid



## Chapter 1 Get started as a member

---

Benefits cost sharing help under Hawaii Med-QUEST Division Program (Medicaid). In addition, you must be enrolled in the QUEST Integration program through 'Ohana Health Plan.

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6-months, then you're still eligible for membership. Chapter 4, Section 2 tells you about coverage and cost sharing during a period of deemed continued eligibility.

### Section 2.2 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). Eligible beneficiaries also receive full Medicaid benefits.
- **Specified Low-Income Medicare Beneficiary Plus (SLMB+):** Helps pay Part B premiums. Eligible beneficiaries also receive full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** Medicaid may pay for your Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). Eligible beneficiaries also receive full Medicaid benefits.

### Section 2.3 Plan service area for Wellcare 'Ohana Dual Align (HMO-POS D-SNP)

Wellcare 'Ohana Dual Align (HMO-POS D-SNP) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Hawaii: Hawaii, Honolulu, Kauai, and Maui.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services 1-888-846-4262 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.



## Chapter 1 Get started as a member

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

### Section 2.4 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Wellcare 'Ohana Dual Align (HMO-POS D-SNP) if you're not eligible to stay a member of our plan on this basis. Wellcare 'Ohana Dual Align (HMO-POS D-SNP) must disenroll you if you don't meet this requirement.

## SECTION 3 Important membership materials

### Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. Sample membership card:

Wellcare 'Ohana Dual Align (HMO-POS D-SNP)	
	<b>MEMBER ID#:</b> 1234567890123 <b>PLAN#:</b> H9916-001-000 <b>ISSUER#:</b> (80840) 9151014609
<b>Member Name:</b> Member Full Name	
<b>Care Coordinator Phone:</b> 1-888-846-4262 (TTY: 711)	<b>Member Services</b> 1-888-846-4262 (TTY: 711)
<b>PCP:</b> Physician Name	<b>Nurse Advice Line</b> 1-800-581-9952 (TTY: 711)
<b>PCP Phone:</b> 1-XXX-XXX-XXXX	<b>Vision: Premier Eye Care</b> 1-855-879-1448 (TTY: 711)
<b>PCP / Specialist Office Visit:</b> \$0 Co-pays: \$0	<b>Dental: HDS</b> 1-844-379-4325 (TTY: 711)
<b>Third Party Liability:</b> Y/N	<b>Provider Services / Pharmacy Prior Auth</b> 1-888-505-1201 (TTY: 711)
	<b>Pharmacist Only</b> 1-833-750-0408 (TTY: 711)
<b>Medicare Rx: RXBIN:</b> 610014 <b>RXPCN:</b> MEDDPRIME <b>RXGRP:</b> 2FFA	<b>Send Claims To:</b> Wellcare By 'Ohana Health Plan Attn: Claims Department P.O. Box 31372 Tampa, FL 33631-3372 Payor ID: 14163
<b>Medicaid Rx: RXBIN:</b> XXXXXX <b>RXPCN:</b> XXX <b>RXGRP:</b> XXXXX	<b>Part D Claims:</b> Wellcare By 'Ohana Health Plan Attn: Medicare Part D Member Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577
<b>Effective Date / Prescription Drug Active Date:</b> MM/DD/YYYY	<b>FOR EMERGENCIES:</b> Dial 911 or go to the nearest Emergency Room
	<b>Website:</b> go.wellcare.com/OhanaHI
	<b>Member Portal:</b> go.wellcare.com/member

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Wellcare 'Ohana Dual Align (HMO-POS D-SNP) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-888-846-4262 (TTY users call 711) right away and we'll send you a new card.

### Section 3.2 Provider & Pharmacy Directory

The *Provider & Pharmacy Directory* [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories) lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other



## Chapter 1 Get started as a member

---

health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

A Medical Group is an association of physicians, including Primary Care Providers (PCPs) and specialists, and other health care providers, including hospitals, that contract with the plan to provide services to enrollees.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is situations where it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when Wellcare 'Ohana Dual Align (HMO-POS D-SNP) authorizes use of out-of-network providers. Most of your health services and benefits are covered by Medicare and because you have Hawaii Med-QUEST Division Program (Medicaid), you get some extra services from our plan. These services must be medically necessary and, in some cases, you may need a referral from your primary care provider. You must get these services from the providers who are in our plan. If you cannot find a provider in our plan who can give you the care you need, we will get you the care you need from a provider outside our plan. In those cases, your primary care provider (PCP) can call Member Services to request an approval for you to see an out-of-network provider.

The most recent list of providers and suppliers is available on our website at [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories).

If you don't have a *Provider & Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-888-846-4262 (TTY users call 711). Requested paper *Provider & Pharmacy Directories* will be mailed to you within 3 business days.

The *Provider & Pharmacy Directory* [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Provider & Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that aren't in our plan's network.

The *Provider & Pharmacy Directory* also shows you which pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have a *Provider & Pharmacy Directory*, you can ask for a copy from Member Services 1-888-846-4262 (TTY users call 711). You can also find this information on our website at [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories).



## Chapter 1 Get started as a member

### Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit in Wellcare 'Ohana Dual Align (HMO-POS D-SNP). The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the Wellcare 'Ohana Dual Align (HMO-POS D-SNP) Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit [go.wellcare.com/druglist-6716](https://go.wellcare.com/druglist-6716) or call Member Services 1-888-846-4262 (TTY users call 711).

## SECTION 4 Summary of Important Costs for 2026

	Your Costs in 2026
<b>Monthly plan premium*</b> *Your premium can be higher than this amount. Go to Section 4.1 for details.	\$0
<b>Maximum out-of-pocket amount</b> This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	\$9,250  You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
<b>Primary care office visits</b>	\$0 copay per visit
<b>Specialist office visits</b>	\$0 copay per visit



## Chapter 1 Get started as a member

	Your Costs in 2026
<b>Inpatient hospital stays</b>	For Medicare-covered admissions, per admission: \$0 copay for each hospital stay. Lifetime Reserve Days \$0 copay per day. Lifetime Reserve Days are additional days that the plan will pay for when members are in a hospital for more than the number of days covered by the plan. Members have a total of 60 reserve days that can be used during their lifetime.
<b>Part D drug coverage deductible</b> (Go to Chapter 6 for details.)	\$0
<b>Part D drug coverage</b> (Go to Chapter 6 for details.)	\$0 copay

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

### Section 4.1 Plan premium

Because the Extra Help program pays the premium on your behalf, you don't pay a separate monthly plan premium for *our plan*.

If you *already* get help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you.** We sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-888-846-4262 (TTY users call 711) and ask for the *LIS Rider*.



## Chapter 1 Get started as a member

---

### Section 4.2 Monthly Medicare Part B Premium

#### Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above to be eligible for our plan, you must maintain your eligibility for Hawaii Med-QUEST Division Program (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most Wellcare 'Ohana Dual Align (HMO-POS D-SNP) members, Hawaii Med-QUEST Division Program (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and Part B premium.

**If Hawaii Med-QUEST Division Program (Medicaid) isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

### Section 4.3 Part D Late Enrollment Penalty

Because you're dually-eligible, the LEP doesn't apply as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or a newsletter from that plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
  - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

**Medicare determines the amount of the Part D late enrollment penalty.** Here's how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable drug



## Chapter 1 Get started as a member

---

coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.

- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is \$38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times \$38.99, which equals \$5.46. This rounds to \$5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year**, because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

**If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review.** Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

### Section 4.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes in income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit [www.Medicare.gov/health-drug-plans/part-d/basics/costs](https://www.Medicare.gov/health-drug-plans/part-d/basics/costs).

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**



## Chapter 1 Get started as a member

---

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

### SECTION 5 More information about your monthly plan premium

---

#### Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September, and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

### SECTION 6 Keep our plan membership record up to date

---

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider/Independent Practice Association (IPA). An IPA is an association of physicians, including PCPs and specialists, and other health care providers, including hospitals, that is contracted with the plan to provide services to members.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

#### If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Hawaii Med-QUEST Division Program (Medicaid))
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home



## Chapter 1 Get started as a member

---

- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services 1-888-846-4262 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

## SECTION 7 How other insurance works with our plan

---

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services 1-888-846-4262 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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



**Chapter 1 Get started as a member**

---

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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



# CHAPTER 2:

## Phone numbers and resources

### SECTION 1 Our plan contacts

For help with claims, billing, or member card questions, call or write to Wellcare 'Ohana Dual Align (HMO-POS D-SNP) Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	<p>1-888-846-4262</p> <p>Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.</p> <p>Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. If you leave a voicemail message, please include your name, and telephone number and a team member will return your call within one (1) business day.</p> <p>Member Services 1-888-846-4262 (TTY users call 711) also has free language interpreter services for non-English speakers.</p>
TTY	<p>711</p> <p>Calls to this number are free.</p> <p>Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.</p>
Write	<p>Wellcare By 'Ohana Health Plan</p> <p>PO Box 31370</p> <p>Tampa, FL 33631-3370</p>
Website	<p><a href="https://go.wellcare.com/OhanaHI">go.wellcare.com/OhanaHI</a></p>

### How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and



## Chapter 2 Phone numbers and resources

change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

### Coverage Decisions for Medical Care – Contact Information

<b>Call</b>	1-888-846-4262 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>TTY</b>	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>Write</b>	Wellcare Coverage Determinations Department - Medical PO Box 31370 Tampa, FL 33631-3370

### Coverage Decisions for Part D drugs – Contact Information

<b>Call</b>	1-888-846-4262 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>TTY</b>	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>Fax</b>	1-866-388-1767



**Chapter 2 Phone numbers and resources****Coverage Decisions for Part D drugs – Contact Information**

<b>Write</b>	Wellcare Pharmacy - Coverage Determinations P.O. Box 31397 Tampa, FL 33631-3397
<b>Website</b>	<a href="https://go.wellcare.com/coveragedetermination">go.wellcare.com/coveragedetermination</a>

**Appeals for Medical Care – Contact Information**

<b>Call</b>	1-888-846-4262 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>TTY</b>	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>Fax</b>	1-866-201-0657
<b>Write</b>	Wellcare Appeals Department - Medical P.O. Box 31368 Tampa, FL 33631-3368

**Appeals for Part D drugs – Contact Information**

<b>Call</b>	1-888-846-4262 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
-------------	---



## Chapter 2 Phone numbers and resources

### Appeals for Part D drugs – Contact Information

<b>TTY</b>	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>Fax</b>	1-866-388-1766
<b>Write</b>	Attn: Pharmacy Appeals P.O. Box 31383 Tampa, FL 33631-3383
<b>Website</b>	<a href="https://go.wellcare.com/OhanaHI">go.wellcare.com/OhanaHI</a>

### How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

### Complaints about Medical Care – Contact Information

<b>Call</b>	1-888-846-4262 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>TTY</b>	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>Fax</b>	1-877-297-3112
<b>Write</b>	Wellcare Grievance Department P.O. Box 31395 Tampa, FL 33631-3395



**Chapter 2 Phone numbers and resources****Complaints about Medical Care – Contact Information**

<b>Medicare website</b>	To submit a complaint about Wellcare 'Ohana Dual Align (HMO-POS D-SNP) directly to Medicare, go to <a href="https://www.Medicare.gov/my/medicare-complaint">www.Medicare.gov/my/medicare-complaint</a> .
-------------------------	--

**Complaints about Part D drugs – Contact Information**

<b>Call</b>	1-888-846-4262 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>TTY</b>	Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>Write</b>	P.O. Box 31384 Tampa, FL 33631-3384
<b>Medicare website</b>	To submit a complaint about Wellcare 'Ohana Dual Align (HMO-POS D-SNP) directly to Medicare, go to <a href="https://www.Medicare.gov/my/medicare-complaint">www.Medicare.gov/my/medicare-complaint</a> .

**How to ask us to pay the cost for medical care or a drug you got**

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.



**Chapter 2 Phone numbers and resources****Payment Requests – Contact Information**

<b>Write</b>	<p>Medical Payment Requests: Wellcare Medical Reimbursement Department PO Box 31370 Tampa, FL 33631-3370</p> <p>Part D Payment Requests: Wellcare Medicare Part D Claims Attn: Member Reimbursement Department P.O. Box 31577 Tampa, FL 33631-3577</p>
<b>Website</b>	<a href="https://go.wellcare.com/OhanaHI">go.wellcare.com/OhanaHI</a>

**SECTION 2 Get help from Medicare**

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

**Medicare – Contact Information**

<b>Call</b>	<p>1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.</p>
<b>TTY</b>	<p>1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.</p>
<b>Chat Live</b>	Chat live at <a href="https://www.Medicare.gov/talk-to-someone">www.Medicare.gov/talk-to-someone</a> .
<b>Write</b>	Write to Medicare at PO Box 1270, Lawrence, KS 66044



## Chapter 2 Phone numbers and resources

### Medicare – Contact Information

#### Website

[www.Medicare.gov](http://www.Medicare.gov)

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.
- Find Medicare-participating doctors or other health care providers and suppliers.
- Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.
- Look up helpful websites and phone numbers.

You can also visit [www.Medicare.gov](http://www.Medicare.gov) to tell Medicare about any complaints you have about our plan.

**To submit a complaint to Medicare,** go to [www.Medicare.gov/my/medicare-complaint](http://www.Medicare.gov/my/medicare-complaint). Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

## SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Hawaii, the SHIP is called Hawaii State Health Insurance Assistance Program (SHIP).

Hawaii State Health Insurance Assistance Program (SHIP) is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Hawaii State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Hawaii State Health Insurance Assistance Program (SHIP) counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.



**Chapter 2 Phone numbers and resources**

<b>Hawaii State Health Insurance Assistance Program (SHIP) – Contact Information</b>	
<b>Call</b>	1-888-875-9229
<b>TTY</b>	1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
<b>Write</b>	Hawaii SHIP, Executive Office on Aging, No. 1 Capitol District 250 South Hotel Street, Suite 406 Honolulu, Hawaii 96813-2831
<b>Website</b>	<a href="http://www.hawaiiiship.org/">http://www.hawaiiiship.org/</a>

**SECTION 4 Quality Improvement Organization (QIO)**

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Hawaii, the Quality Improvement Organization is called Livanta - Hawaii's Quality Improvement Organization.

Livanta - Hawaii's Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta - Hawaii's Quality Improvement Organization is an independent organization. It's not connected with our plan.

Contact Livanta - Hawaii's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

<b>Livanta - Hawaii's Quality Improvement Organization – Contact Information</b>	
<b>Call</b>	1-877-588-1123 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, Saturday - Sunday



**Chapter 2 Phone numbers and resources**

<b>Livanta - Hawaii's Quality Improvement Organization – Contact Information</b>	
<b>TTY</b>	711
<b>Write</b>	Livanta LLC/BFCC-QIO PO Box 2687 Virginia Beach, VA 23450
<b>Website</b>	<a href="https://www.livantaqio.cms.gov/en">https://www.livantaqio.cms.gov/en</a>

**SECTION 5 Social Security**

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount, or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

<b>Social Security— Contact Information</b>	
<b>Call</b>	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
<b>Website</b>	<a href="http://www.SSA.gov">www.SSA.gov</a>



## Chapter 2 Phone numbers and resources

### SECTION 6 Medicaid

As a member of our plan, you are eligible for both Medicare and Hawaii Med-QUEST Division Program (Medicaid). Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through Hawaii Med-QUEST Division Program (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). Eligible beneficiaries also receive full Medicaid benefits.
- **Specified Low-Income Medicare Beneficiary Plus (SLMB+):** Helps pay Part B premiums. Eligible beneficiaries also receive full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** Medicaid may pay for your Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). Eligible beneficiaries also receive full Medicaid benefits.

To be a member of this plan you should be dually enrolled in both Medicare and Hawaii Med-QUEST Division Program (Medicaid) and meet all other plan eligibility requirements at time of enrollment. If you have questions about the help you get from Medicaid, contact Hawaii Med-QUEST Division Program (Medicaid).

Hawaii Med-QUEST Division Program (Medicaid) – Contact Information	
<b>Call</b>	1-800-316-8005 1-808-524-3370 7:45 a.m. - 4:30 p.m. HT, Monday - Friday
<b>TTY</b>	711
<b>Write</b>	Hawaii Med-QUEST Division Program (Medicaid) 1350 S. King Street, Suite 200 Honolulu, HI 96814
<b>Website</b>	<a href="https://medquest.hawaii.gov/en.html">https://medquest.hawaii.gov/en.html</a>

The State of Hawaii Office of the Ombudsman helps people enrolled in Hawaii Med-QUEST Division Program (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.



## Chapter 2 Phone numbers and resources

State of Hawaii Office of the Ombudsman - Contact Information	
<b>Call</b>	1-808-587-0770 7:45 a.m. - 4:30 p.m. local time, Monday - Friday
<b>TTY</b>	1-808-587-0774 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
<b>Write</b>	Office of the Ombudsman 465 South King Street, 4th Floor Honolulu, Hawaii 96813
<b>Website</b>	<a href="https://www.ombudsman.hawaii.gov/">https://www.ombudsman.hawaii.gov/</a>

The Hawaii Long-Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Hawaii Long-Term Care Ombudsman Program – Contact Information	
<b>Call</b>	1-808-586-7268 7:45 a.m. - 4:30 p.m. local time, Monday - Friday
<b>TTY</b>	711
<b>Write</b>	Executive Office on Aging 250 South Hotel Street , Suite 406 Honolulu, HI 96813
<b>Website</b>	<a href="https://www.hi-ltc-ombudsman.org/">https://www.hi-ltc-ombudsman.org/</a>

## SECTION 7 Programs to help people pay for prescription drugs

The Medicare website ([www.Medicare.gov/basics/costs/help/drug-costs](https://www.Medicare.gov/basics/costs/help/drug-costs)) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

### Extra Help from Medicare

Because you're eligible for Hawaii Med-QUEST Division Program (Medicaid), you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't need to do anything further to get this Extra Help.



## Chapter 2 Phone numbers and resources

---

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office at 1-800-316-8005, TTY users call 711.

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of your proper copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Call Member Services and tell the representative that you think you qualify for Extra Help. You may be required to provide one of the following types of documentation (Best Available Evidence):
  - A copy of the beneficiary's Hawaii Med-QUEST Division Program (Medicaid) card that includes the beneficiary's name and eligibility date during a month after June of the previous calendar year
  - A copy of a State document that confirms active Hawaii Med-QUEST Division Program (Medicaid) status during a month after June of the previous calendar year
  - A print out from the State electronic enrollment file showing Hawaii Med-QUEST Division Program (Medicaid) status during a month after June of the previous calendar year
  - A screen print from the State's Hawaii Med-QUEST Division Program (Medicaid) systems showing Medicaid status during a month after June of the previous calendar year
  - Other documentation provided by the State showing Hawaii Med-QUEST Division Program (Medicaid) status during a month after June of the previous calendar year
  - A letter from Social Security Administration (SSA) showing that the individual receives Supplemental Security Income (SSI)
  - An Application Filed by Deemed Eligible confirming that the beneficiary is "...automatically eligible for Extra Help..." (SSA publication HI 03094.605)

If you are institutionalized and believe you qualify for zero cost sharing, call Member Services and tell the representative that you believe you qualify for Extra Help. You may be required to provide one of the following types of documentation:

- A remittance from the facility showing Medicaid payment on your behalf for a full calendar month during a month after June of the previous calendar year;
- A copy of a state document that confirms Medicaid payment on your behalf to the facility for a full calendar month after June of the previous calendar year; or



## Chapter 2 Phone numbers and resources

- A screen print from the State's Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.
- If you are unable to provide the documentation described above and you believe that you may qualify for Extra Help, call Member Services and a representative will assist you.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at 1-888-846-4262 (TTY users call 711) if you have questions.

### What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Hawaii HIV Drug Assistance Program (HDAP).

The Hawaii HIV Drug Assistance Program (HDAP) is your state's ADAP.

The Hawaii HIV Drug Assistance Program (HDAP) in your state is listed below.

Hawaii HIV Drug Assistance Program (HDAP) — Contact Information	
<b>Call</b>	1-808-733-9360 8 a.m. - 5 p.m. local time, Monday - Friday
<b>TTY</b>	711
<b>Write</b>	Harm Reduction Services 3627 Kilauea Ave, Suite 306 Honolulu, HI 96816
<b>Website</b>	<a href="https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/">https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/</a>

**Note:** To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call Hawaii HIV Drug Assistance Program (HDAP).



## Chapter 2 Phone numbers and resources

### SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

#### Railroad Retirement Board (RRB) – Contact Information

<b>Call</b>	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday.</p> <p>Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.</p>
<b>TTY</b>	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.</p> <p>Calls to this number aren't free.</p>
<b>Website</b>	<p><a href="https://RRB.gov">https://RRB.gov</a></p>

### SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-888-846-4262 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.



## CHAPTER 3:

# Using our plan for your medical and other covered services

### SECTION 1 How to get medical care and other services as a member of our plan

---

This chapter explains what you need to know about using our plan to get your medical care and other services covered. For details on what medical care and other services our plan covers, go to the Medical Benefits Chart in Chapter 4.

#### Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

#### Section 1.2 Basic rules for your medical care and other services to be covered by our plan

As a Medicare and Hawaii Med-QUEST Division Program (Medicaid) health plan, our plan must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare. Please refer to Chapter 4 for services covered under the plan.

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



## Chapter 3 Using our plan for your medical and other covered services

---

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
  - Discuss your treatment plan with your PCP in advance to coordinate your care before you use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. Prior authorization is required for some services. For more information about these services, please see the Medical Benefits Chart in Chapter 4, Section 2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered, except as mentioned below. This means you have to pay the provider in full for the services you get. Here are 3 exceptions:
  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare or Hawaii Med-QUEST Division Program (Medicaid) requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network provider (prior authorization is required). In this situation, we'll cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.
- **The Point-of-Service (POS) benefit allows you to access certain services from non-network providers.** Not all services are covered out-of-network under your Point of Service (POS) option. For covered services out-of-network, please refer to the Medical Benefit Chart in Chapter 4, Section 2 for more information. You will pay more to access these services when you use your POS benefit. For more information see Section 2.4 of this chapter.

You don't need to get a referral when you get care from out-of-network providers for these services. However, before getting these services you may want to confirm that they are covered



**Chapter 3 Using our plan for your medical and other covered services**

---

by us. If we later determine that the services are not covered, we may deny coverage and you will be responsible for the costs. Prior authorization may be required for some services.

**SECTION 2 Use providers in our plan's network to get medical care and other services**

---

**Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care****What is a PCP and what does the PCP do for you?**

When you become a member of our plan, you must first choose a plan provider to be your PCP. Your PCP is your partner in health, providing or coordinating your care. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. These include doctors specializing in family practice, general practice, internal medicine, and geriatrics. A nurse practitioner (NP), a State licensed registered nurse with special training, providing a basic level of health care, or a Physician Assistant (PA), credentialed as a PCP, providing services within a primary care setting can also act as your PCP.

You will get most of your routine or basic care from your PCP. Your PCP will also help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes:

- X-rays,
- Laboratory tests,
- Physical, Occupational and/or Speech Therapies,
- Care from doctors who are specialists,
- Hospital admissions, and
- Follow-up care

“Coordinating” your covered services includes checking or consulting with other plan providers about your care and how it is going. For certain types of services or supplies, your PCP will need to get prior authorization (approval in advance). If the service you need requires prior authorization, your PCP will request the authorization from our plan. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. You will usually see your PCP first for most of your routine health care needs. We recommend you have your PCP coordinate all of your care. Please refer to Section 2.2 in this chapter for more information.



## Chapter 3 Using our plan for your medical and other covered services

---

In some cases, your PCP, or a specialist or other provider you're seeing, will need to obtain prior authorization (prior approval) from us for certain types of covered services and items. See Chapter 4 of this document for services and items that require prior authorization.

If you need to talk to your physician after normal business hours, call the physician's office and you will be directed to your physician, an answering machine with directions on where to obtain service, or another physician that is providing coverage. If you are experiencing an emergency, immediately call 911.

### How to choose a PCP

To choose your PCP, go to our website at [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories) and select a PCP from our plan network. Member Services can also help you choose a PCP. Once you have chosen your PCP call Member Services with your selection. Your PCP must be in our network.

If there is a particular plan specialist or hospital that you want to use, check first to be sure that the specialists and/or hospitals are in the PCP's network.

If you do not choose a PCP or if you chose a PCP that is not available with this plan, we will automatically assign you to a PCP.

### How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. Under certain circumstances, our providers are obligated to continue care after leaving our network. For specific details, contact Member Services.

If you wish to change your PCP, please call Member Services. Each plan PCP may make referrals to certain plan specialists and uses certain hospitals within their network. This means that the plan PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your plan PCP uses these specialists or hospitals.

Member Services can help you select a new PCP. If you request the change on or before the 10th of the month, it takes effect retroactively on the 1st of that month. If you call or request after the 10th, the change is effective the 1st of the following month. Example: A PCP request made by January 10th is effective January 1st. A request made on or after January 11th is effective February 1st. Until the change takes effect, continue using your current PCP for all covered services. When calling Member Services, mention any specialists or services (like home health or DME) that required your current PCP's approval.

## Section 2.2 Medical care and other services you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.



## Chapter 3 Using our plan for your medical and other covered services

---

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-888-846-4262 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

### Section 2.3 How to get care from specialists and other network providers

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

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

Discuss your health care needs with your PCP to get a recommendation to see a specialist that supports your care needs. A referral is not required to see a specialist. However, in some cases, you, your representative or your PCP/provider may need to get prior authorization from the plan. Please see Chapter 4, Section 2 for information about which services require prior authorization.

### When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.



**Chapter 3 Using our plan for your medical and other covered services**

---

- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Our plan must confirm there is not a network provider available, and the out-of-network provider must contact the plan to request an authorization for you to obtain services. If approved, the out-of-network provider will be issued an authorization to provide the service(s). You are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, our plan must cover dialysis services for members with End-Stage Renal Disease (ESRD) who have traveled outside the plan's service area and are not able to access network providers. ESRD services must be received at a Medicare-certified dialysis facility.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

**Section 2.4 How to get care from out-of-network providers**

You are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, our plan must cover dialysis services for members with End-Stage Renal Disease (ESRD) who have traveled outside the plan's service area and are not able to access network providers. ESRD services must be received at a Medicare-certified dialysis facility.

Also, if you need Medicare-covered medical care and a network provider is unable to provide this care, you may be able to get care from an out-of-network provider. Our plan must confirm there is not a



## Chapter 3 Using our plan for your medical and other covered services

---

network provider available, and the out-of-network provider must contact the plan to request an authorization for you to obtain services. If approved, the out-of-network provider will be issued an authorization to provide the service(s).

Through the Point-of-Service (POS) benefit, you may use out-of-network providers to get certain services. For covered services out-of-network, please refer to the Medical Benefit Chart in Chapter 4, Section 2 for more information. You will pay more to access these services when you use your POS benefit. Your out-of-pocket costs may be higher when you use out-of-network providers through your POS benefit. You don't need to get a referral when you go out-of-network for these services. However, before getting these services you may want to confirm with us that they are covered. If we later determine that the services are not covered, we may deny coverage and you will be responsible for the costs. Prior authorization may be required for some services.

If an out-of-network provider sends you a bill that you think we should pay, please contact Member Services or send the bill to us for payment. We will pay your provider for our share of the bill and your provider may bill you for the amount you owe, if any.

## SECTION 3 How to get services in an emergency, disaster, or urgent need for care

---

### Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. Wellcare 'Ohana Dual Align (HMO-POS D-SNP) includes world-wide emergency/urgent coverage.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You can call Member Services at the number located on the back of your membership card.



## Chapter 3 Using our plan for your medical and other covered services

---

### Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. It is important that you follow up with your primary care provider within 5 to 7 days after you receive emergency care. You will receive a call from our care team to help you obtain needed follow up appointments and obtain other helpful recovery benefits. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

### What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

### Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Please contact your PCP's office 24 hours a day if you need urgent care. You may be directed to obtain urgent care at a network urgent care center. A list of network urgent care centers can be found in the *Provider & Pharmacy Directory* or on our website at [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories). If urgent care services are received in your doctor's office, you will pay the office visit copayment; however, if



## Chapter 3 Using our plan for your medical and other covered services

---

urgent care services are received at a network urgent care center or walk-in clinic, you will pay the urgent care center copayment, which may be different. See Chapter 4, for the copayment that applies to services provided in a doctor's office or network urgent care center or walk-in clinic.

You may also contact the Nurse Advice Line at any time. A nursing professional is standing by with answers to your questions 24 hours a day, seven days a week. For more information regarding the Nurse Advice Line, see the Health and Wellness Education Programs benefit category in Chapter 4, or call Member Services.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances. However, Medicare does not cover emergency care outside of the United States.

- You are covered for up to \$50,000 when traveling outside the United States under your worldwide emergency and urgent care coverage. Costs that exceed this amount will *not* be covered.
- Transportation back to the United States from another country and medication purchased while outside of the United States are *not* covered. Additionally, emergency room cost shares are *not* waived if you are admitted for inpatient hospital care.
- Please contact us within 48 hours, if possible, to advise us of your emergency room visit.

For more information, see “Emergency Care” and “Urgently Needed Services” in the Medical Benefits Chart in Chapter 4 of this document or call Member Services.

### Section 3.3 Get care during a disaster

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

Visit [go.wellcare.com/OhanaHI](https://go.wellcare.com/OhanaHI) for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

## SECTION 4 What if you're billed directly for the full cost of covered services?

---

If you paid for your covered services, or if you get a bill for covered medical services, go to Chapter 7 for information about what to do.



## Chapter 3 Using our plan for your medical and other covered services

---

### Section 4.1 If services aren't covered by our plan

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, or you get services out-of-network without authorization, you're responsible for paying the full cost of services. Before paying for the cost of services, you should check to see if the service is covered by Hawaii Med-QUEST Division Program (Medicaid).

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. The amount you pay for the costs once a benefit limit has been reached will not count toward the out-of-pocket maximum. For example, you may have to pay the full cost of any skilled nursing facility care you get after our plan's payment reaches the benefit limit. Once you have used up your benefit limit, additional payments you make for the service do not count toward your annual out-of-pocket maximum.

## SECTION 5 Medical services in a clinical research study

---

### Section 5.1 What is a clinical research study

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

**If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study.** If you tell us that you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.



## Chapter 3 Using our plan for your medical and other covered services

---

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

### Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

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

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you'll pay nothing for the covered services you get in the clinical research study.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

### Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at [www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf](http://www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf).) You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

---

### Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious



## Chapter 3 Using our plan for your medical and other covered services

---

non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

### Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that's **non-excepted**.

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

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

## SECTION 7 Rules for ownership of durable medical equipment

---

### Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.



## Chapter 3 Using our plan for your medical and other covered services

---

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, there are also certain types of DME you will own after paying copayments for the item for a specified number of months. Your previous payments towards a DME item when you had Original Medicare do not count towards payments you make while a member of our plan. If you acquire ownership of a DME item while you are a member of our plan, and the equipment requires maintenance, the provider is allowed to bill the plan for the cost of the repair. There are also certain types of DME for which you will not acquire ownership no matter how many payments you make for the item while a member of our plan. Call Member Services to find out about the rental or ownership requirements of DME and the documentation you need to provide.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

## **Section 7.2 Rules for oxygen equipment, supplies, and maintenance**

If you qualify for Medicare oxygen equipment coverage Wellcare 'Ohana Dual Align (HMO-POS D-SNP) will cover:

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

If you leave Wellcare 'Ohana Dual Align (HMO-POS D-SNP) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

### **What happens if you leave our plan and return to Original Medicare?**

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over



**Chapter 3 Using our plan for your medical and other covered services**

---

again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.



**Chapter 4 Medical Benefits Chart (what's covered)**

---

# CHAPTER 4:

## Medical Benefits Chart

### (what's covered)

#### **SECTION 1 Understanding covered services**

---

The Medical Benefits Chart lists your covered services as a member of our plan. This section also gives information about medical services that aren't covered and explains limits on certain services.

##### **Section 1.1 You pay nothing for your covered services**

Because you get help from Hawaii Med-QUEST Division Program (Medicaid), you pay nothing for your covered services as long as you follow our plans' rules for getting your care. (Go to Chapter 3 for more information about the plans' rules for getting your care.)

##### **Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?**

**Note:** Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is \$9,250.**

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk (\*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$9,250, you won't have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Hawaii Med-QUEST Division Program (Medicaid) or another third party).



**Chapter 4 Medical Benefits Chart (what's covered)**

---

**SECTION 2 The Medical Benefits Chart shows your medical benefits and costs**

---

The Medical Benefits Chart on the next pages lists the services our plan covers (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare and Hawaii Med-QUEST Division Program (Medicaid) covered services must be provided according to Medicare and Hawaii Med-QUEST Division Program (Medicaid) coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- You're covered by both Medicare and Hawaii Med-QUEST Division Program (Medicaid). Medicare covers health care and prescription drugs. Hawaii Med-QUEST Division Program (Medicaid) covers your cost sharing for Medicare services, including Medicare deductibles and copayment or coinsurance amounts for inpatient and outpatient hospital services and doctor office visits. Hawaii Med-QUEST Division Program (Medicaid) also covers services Medicare doesn't cover, like long-term care, some over-the-counter drugs, and home and community-based services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook.)



## Chapter 4 Medical Benefits Chart (what's covered)

---

View it online at [www.Medicare.gov](http://www.Medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.
- Under our plan, we will provide coverage for some Hawaii Med-QUEST Division Program (Medicaid) benefits as required in our plan's agreement with your State Medicaid Agency. The Medical Benefits Chart in Chapter 4 states what benefits are covered under the plan. The Medical Benefits Chart will also state any benefit limitations or authorizations that apply. For Hawaii Med-QUEST Division Program (Medicaid) covered services, please refer to the plan Summary of Benefits for a complete list of benefits covered by Hawaii Med-QUEST Division Program (Medicaid). If you didn't receive a Summary of Benefits, please call Member Services and ask them to send you a copy. Your cost sharing for Hawaii Med-QUEST Division Program (Medicaid) covered services, if any, is based on your level of Hawaii Med-QUEST Division Program (Medicaid) eligibility.
- If you are within our plan's 6-months period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, the Medicare Advantage plan is not responsible for coverage of any Hawaii Med-QUEST Division Program (Medicaid) benefits that may be included under your Medicaid State Plan.

You don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

### *Important Benefit Information for Enrollees with Chronic Conditions*

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - **Autoimmune disorders (includes Rheumatoid arthritis)**
  - **Cancer**
  - **Cardiovascular disorders (includes Hypertension)**
  - **Chronic alcohol use disorder and other substance use disorders (SUDs)**
  - **Chronic heart failure**
  - **Chronic lung disorders**
  - **Chronic and disabling mental health conditions**
  - **Chronic gastrointestinal disease (includes Chronic gastrointestinal disorders)**
  - **Chronic kidney disease (CKD)**
  - **Conditions with functional challenges (includes End Stage Renal Disease (ESRD), End Stage Liver Disease, Osteoporosis (bone disease), Osteoarthritis)**



## Chapter 4 Medical Benefits Chart (what's covered)

---

- **Conditions that require continued therapy services in order for individuals to maintain or retain functioning (includes Muscular Dystrophy)**
- **Conditions associated with cognitive impairment (includes Down Syndrome)**
- **Dementia**
- **Diabetes mellitus**
- **Endometriosis**
- **HIV/AIDS**
- **Neurologic disorders**
- **Overweight, obesity, and metabolic syndrome (includes Hyperlipidemia/Dyslipidemia)**
- **Post-organ transplantation**
- **Severe hematologic disorders**
- **Stroke**
- Your plan includes Special Supplemental Benefits for the Chronically Ill (SSBCI). These supplemental benefits are only offered to high-risk, chronically ill members who also meet additional criteria for eligibility.
- **Members must meet and maintain all three eligibility criteria below to qualify:**
  1. The member must require **intensive** care management.
  2. The member must be at **high risk** for unplanned hospitalization.
  3. The member must have a documented and active diagnosis for a qualifying chronic condition. The chronic condition must be **life threatening or significantly limit the overall health or function of the member.**
- Wellcare will notify you if eligible, and you will receive a letter with instructions on how to access the benefit.
- New members may be eligible for SSBCI benefits if your provider attests that you meet the qualifying criteria.
- Copays or other costs not covered by your plan may apply.
- Confirmation that all criteria has been met is required prior to receiving access to these benefits.
- All benefits end on 12/31/2026 and members will be required to re-qualify each plan year.
- For more details, go to the *Special Supplemental Benefits for the Chronically Ill* row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.



This apple shows the preventive services in the Medical Benefits Chart.



**Chapter 4 Medical Benefits Chart (what's covered)****Medical Benefits Chart****Covered Service****What you pay**

**For Hawaii Med-QUEST Division Program (Medicaid) covered services, please refer to the plan Summary of Benefits for a complete list of benefits covered by Medicaid. If you didn't receive a Summary of Benefits, please call Member Services and ask them to send you a copy. Your cost sharing for Medicaid covered services, if any, is based on your level of Medicaid eligibility. Please contact your state Medicaid agency to determine your level of cost sharing.**

**Abdominal aortic aneurysm screening**

A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.

There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

**Acupuncture for chronic low back pain**

Covered services include:

Up to 12 visits in 90 days are covered under the following circumstances:

For the purpose of this benefit, chronic low back pain is defined as:

- Lasting 12 weeks or longer;
- nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.);
- not associated with surgery; and
- not associated with pregnancy.

An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.

Treatment must be discontinued if the patient is not improving or is regressing.

**Provider Requirements:**

Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.

\$0 copay for Medicare-covered acupuncture received in a PCP office.

\$0 copay for Medicare-covered acupuncture received in a Specialist office.  
*Prior Authorization may be required.*

\$0 copay for Medicare-covered acupuncture received in a Chiropractor office.  
*Prior Authorization may be required.*



Covered Service	What you pay
<p><b>Acupuncture for chronic low back pain - continued</b></p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"><li>• a master’s or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,</li><li>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.</li></ul> <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p><b>Acupuncture for other conditions</b></p> <p><b>Our plan also covers supplemental (Non-Medicare-covered) acupuncture services up to a total of 24 visits every year.</b></p> <p>In most cases, you must use a contracted provider to receive covered services. Please contact our plan if you have questions on how to use this benefit.</p> <p>Covered acupuncture services include:</p> <ul style="list-style-type: none"><li>• A new patient exam or an established patient exam for the first evaluation of a patient with a new health issue or new flare-up</li><li>• Established patient exams (within 3 years of a new exam)</li><li>• Follow up office visits—may involve acupuncture services or a re-exam</li><li>• Second opinion with a different provider in the network</li><li>• Urgent and emergent services</li></ul> <p>For assistance finding a network provider, you can call Member Services.</p>	<p>\$0 copay for each supplemental (Non-Medicare covered) acupuncture visit.* <i>Prior Authorization may be required.</i></p>






**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Ambulance services</b></p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.</p>	<p>\$0 copay per one-way trip for Medicare-covered ground ambulance services. <i>Prior authorization may be required for fixed wing aircraft and non-emergent transportation.</i></p> <p>\$0 copay per one-way trip for Medicare-covered air ambulance services. <i>Prior authorization may be required for fixed wing aircraft and non-emergent transportation.</i> The cost share is not waived if you are admitted for Inpatient hospital care.</p>
<p><b>Annual routine physical exam</b></p> <p>Annual physical exam includes examination of the heart, lung, abdominal and neurological systems, as well as a hands-on examination of the body (such as head, neck and extremities) and detailed medical/family history, in addition to services included in the Annual Wellness Visit. The following are examples of services that may be performed or ordered during your exam:</p> <ul style="list-style-type: none"> <li>• Take routine measurements (height, weight, blood pressure)</li> <li>• Assess risk factors for preventable diseases</li> <li>• Check reflexes and vital signs</li> <li>• Lab testing (urine and blood samples)</li> </ul>	<p>\$0 copay for an annual routine physical exam.*</p>






**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
 <b>Annual wellness visit</b>  <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year.</p> <p><b>Note:</b> Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
 <b>Bone mass measurement</b>  <p>For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
 <b>Breast cancer screening (mammograms)</b>  <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women aged 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>



**Chapter 4 Medical Benefits Chart (what's covered)**


Covered Service	What you pay
<p><b>Cardiac rehabilitation services</b></p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.</p> <p>Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$0 copay for Medicare-covered cardiac rehabilitation services.</p> <p>\$0 copay for Medicare-covered intensive cardiac rehabilitation services.</p>
<p> <b>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</b></p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> <b>Cardiovascular disease screening tests</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> <b>Cervical and vaginal cancer screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months</li> </ul>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>



Covered Service	What you pay
<p><b>Chiropractic services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>Manual manipulation of the spine to correct subluxation</li></ul> <p><b>Our plan also covers supplemental (Non-Medicare-covered) chiropractic visits up to a total of 12 visits every year.</b></p> <p>Supplemental (Non-Medicare-covered) chiropractic services to support the back, neck, or joints of the arms and legs are limited by medical necessity.</p> <p>Covered chiropractic services include:</p> <ul style="list-style-type: none"><li>An initial exam (New Patient exam or an Established Patient exam for the first evaluation of a new health issue or new flare-up.)</li><li>Re-exams (Established patient exams, when necessary to evaluate progress or modify treatment), Manipulation of the spine, or joints, and/or other services (these services may be provided on the same visit as an exam)</li><li>X-ray and lab services when provided by or referred by a contracted chiropractor. X-ray and lab services performed outside of a new or established patient visit will assess an individual copay.</li></ul> <p>For assistance finding a network provider, you can call Member Services.</p> <p><b>Note:</b> Coverage of routine chiropractor services is a supplemental benefit offered by the plan. Neither Medicare nor Hawaii Med-QUEST Division Program (Medicaid) will pay your share of the cost for these services.</p>	<p>\$0 copay for Medicare-covered chiropractic services. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for each supplemental (Non-Medicare-covered) chiropractor visit.* <i>Prior Authorization may be required.</i></p>




**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Chronic pain management and treatment services</b></p> <p>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.</p>	<p>Cost sharing for this service will vary depending on individual services provided under the course of treatment. See "Physician/Practitioner services, including doctor's office visit" later in this chart for any applicable cost share amounts for Medicare-covered primary care or specialist office visits where these services are provided.</p>
<p> <b>Colorectal cancer screening</b></p> <p>The following screening tests are covered:</p> <ul style="list-style-type: none"> <li>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.</li> <li>• Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.</li> <li>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after</li> </ul>	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and subject to a \$0 copay for your doctors' services.</p>



Chapter 4 Medical Benefits Chart (what’s covered)

Covered Service	What you pay
<div> <b>Colorectal cancer screening - continued</b></div> <div><p>the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography.</p><ul style="list-style-type: none"><li>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.</li><li>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li><li>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li><li>• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.</li><li>• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.</li></ul></div>	
<div><b>Dental services</b></div> <div><p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren’t covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person’s primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover:</p><p><b><u>Supplemental (i.e., routine) dental services</u></b></p><p>There is a plan benefit allowance of \$3,000 every year for all in-network and out-of-network covered Comprehensive Dental</p></div>	<div><p>\$0 copay for each Medicare-covered dental services.</p><p><i>Prior Authorization may be required.</i></p></div>



Covered Service	What you pay
<p><b>Dental services - continued</b></p> <p>services. You are responsible for amounts beyond the benefit allowance.*</p> <ul style="list-style-type: none"><li><b>Diagnostic and Preventive Dental Care</b> (Covered services include the following.)<ul style="list-style-type: none"><li>Other Diagnostic dental services - 1 every day to 1 plan year depending on type of service</li><li>Other Preventive Dental services - 1 every day to 1 year depending on type of service</li></ul></li><li><b>Comprehensive Dental Care</b> (Covered services include the following.)<ul style="list-style-type: none"><li>Restorative services - 1 every 1 to 7 plan years depending on type of service</li></ul></li></ul>	<p><b>In-Network</b> \$0 copay for other diagnostic dental services per visit.* <i>Prior Authorization may be required.</i></p> <p><b>Out-of-Network<sup>†</sup></b> 25% coinsurance for other diagnostic dental services per visit.* <i>Prior Authorization may be required.</i></p> <p><b>In-Network</b> \$0 copay for other preventive dental services per visit.* <i>Prior Authorization may be required.</i></p> <p><b>Out-of-Network<sup>†</sup></b> 25% coinsurance for other preventive dental services per visit.* <i>Prior Authorization may be required.</i></p> <p><b>In-Network</b> \$0 copay for each restorative service.* <i>Prior Authorization may be required.</i></p>





Covered Service	What you pay
Dental services - continued	
<ul style="list-style-type: none"><li>Endodontics -</li></ul>	<p><b>Out-of-Network<sup>*</sup></b> 25% coinsurance for each restorative service.* <i>Prior Authorization may be required.</i></p> <p><b>In-Network</b> \$0 copay for each endodontic service.* <i>Prior Authorization may be required.</i></p>
<ul style="list-style-type: none"><li>Periodontics -</li></ul>	<p><b>Out-of-Network<sup>*</sup></b> 25% coinsurance for each endodontic service.* <i>Prior Authorization may be required.</i></p> <p><b>In-Network</b> \$0 copay for each periodontic service.* <i>Prior Authorization may be required.</i></p>
<ul style="list-style-type: none"><li>Oral/Maxillofacial surgery - 1 per lifetime</li></ul>	<p><b>Out-of-Network<sup>*</sup></b> 25% coinsurance for each periodontic service.* <i>Prior Authorization may be required.</i></p> <p><b>In-Network</b> \$0 copay for each oral maxillofacial service.* <i>Prior Authorization may be required.</i></p> <p><b>Out-of-Network<sup>*</sup></b> 25% coinsurance for each oral maxillofacial service.* <i>Prior Authorization may be required.</i></p>



Covered Service	What you pay
<b>Dental services - continued</b> <ul style="list-style-type: none"><li>○ Prosthodontics, fixed -</li><li>○ Prosthodontics, removable - 1 every 6 months to 5 years depending on type of service</li><li>○ Adjunctive general services - unlimited every year</li></ul> <p>Before obtaining services, members are advised to discuss their treatment options with a routine dental services participating provider. Treatment must be started and completed while covered by the plan during the plan year. The cost of dental</p>	<p><b>In-Network</b> \$0 copay for each fixed prosthodontic service.* <i>Prior Authorization may be required.</i></p> <p><b>Out-of-Network<sup>*</sup></b> 25% coinsurance for each fixed prosthodontic service.* <i>Prior Authorization may be required.</i></p> <p><b>In-Network</b> \$0 copay for each removable prosthodontic service. * <i>Prior Authorization may be required.</i></p> <p><b>Out-of-Network<sup>*</sup></b> 25% coinsurance for each removable prosthodontic service.* <i>Prior Authorization may be required.</i></p> <p><b>In-Network</b> \$0 copay for each adjunctive general service. * <i>Prior Authorization may be required.</i></p> <p><b>Out-of-Network<sup>*</sup></b> 25% coinsurance for each adjunctive general service.* <i>Prior Authorization may be required.</i></p> <p><b><sup>*</sup>If you choose to see an out-of-network dentist, your out-of-pocket costs may be higher. Out-of-network dental providers are not</b></p>





**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Dental services - continued</b></p> <p>services not covered by the plan is the responsibility of the member.</p> <p><b>For questions on how to find a provider, file a claim, or for more information call Member Services.</b></p> <p><b>You can find additional dental coverage information, including a detailed list of covered procedures, in our Dental Benefit Details at: <a href="https://go.wellcare.com/dentalbenefits-hi">go.wellcare.com/dentalbenefits-hi</a></b></p> <p><b>Note:</b> Coverage of routine dental services is a supplemental benefit offered by the plan. Neither Medicare nor Hawaii Med-QUEST Division Program (Medicaid) will pay your share of the cost for these services.</p> <p>Members also enrolled in Hawaii Med-QUEST Division Program (Medicaid) may be eligible for secondary coverage of supplemental dental services by the State. Before obtaining dental services ask the provider if they are able to bill Hawaii Med-QUEST Division Program (Medicaid) as the secondary payer. Be sure to show the provider your Hawaii Med-QUEST Division Program (Medicaid) identification card.</p>	<p><b>contracted to accept plan payment as payment in full. If they charge you more than what the Plan pays, you are responsible for the difference, even for services that have a \$0 copay.</b></p>
<p> <b>Depression screening</b></p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
<p> <b>Diabetes screening</b></p> <p>We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>




**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
 <b>Diabetes screening - continued</b>  You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	
 <b>Diabetes self-management training, diabetic services, and supplies</b>  For all people who have diabetes (insulin and non-insulin users). Covered services include: <ul style="list-style-type: none"> <li>Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> <li>For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>Diabetes self-management training is covered under certain conditions.</li> </ul> Accu-Chek Guide™ and True Metrix™ products by Lifescan are our preferred diabetic testing supplies (glucose monitors & test strips). To get more information about the items that are on the preferred diabetic testing supplies list, please contact Member Services. If you use diabetic testing supplies that are not preferred by the plan, speak with your provider to get a new prescription or to	<p>\$0 copay for Medicare-covered diabetes monitoring supplies. <i>Prior Authorization may be required.</i> However, you may still pay up to 20% of the amount for products which Hawaii Med-QUEST Division Program (Medicaid) does not cover.</p> <p>\$0 copay for Medicare-covered therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. <i>Prior Authorization may be required.</i> However, you may still pay up to 20% of the amount for products which Hawaii Med-QUEST Division Program (Medicaid) does not cover.</p> <p>\$0 copay for Medicare-covered diabetes self-management training. However, you may still pay up to 20% of the amount for products which Hawaii Med-QUEST Division Program (Medicaid) does not cover.</p>




**Chapter 4 Medical Benefits Chart (what's covered)**


Covered Service	What you pay
 <b>Diabetes self-management training, diabetic services, and supplies - continued</b>  request prior authorization for a non-preferred blood glucose monitor and test strips.	
<b>Durable medical equipment (DME) and related supplies</b>  (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at <a href="https://go.wellcare.com/2026providerdirectories">go.wellcare.com/2026providerdirectories</a> .	\$0 copay for Medicare-covered durable medical equipment. <i>Prior Authorization may be required.</i> \$0 copay for Medicare-covered medical supplies. <i>Prior Authorization may be required.</i> Your cost sharing for Medicare oxygen equipment coverage is \$0 copay every 36 months. Your cost sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost sharing in our plan is \$0 copay.
<b>Emergency care</b>  Emergency care refers to services that are: <ul style="list-style-type: none"> <li>• Furnished by a provider qualified to furnish emergency services, and</li> <li>• Needed to evaluate or stabilize an emergency medical condition.</li> </ul>	\$0 copay for Medicare-covered emergency room visits.  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is



**Chapter 4 Medical Benefits Chart (what's covered)**


Covered Service	What you pay
<p><b>Emergency care - continued</b></p> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.</p> <p>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.</p> <p>Emergency services outside the United States are covered.</p>	<p>stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.</p> <p>\$115 copay for emergency services outside of the United States.* You pay this amount even if you are admitted to the hospital within 24 hours for the same condition.</p> <p>You are covered for up to \$50,000 every year for emergency or urgently needed services outside the United States.</p>
<p> <b>Health and wellness education programs</b></p> <ul style="list-style-type: none"> <li> <p><b>Nurse advice line</b></p> <p>Toll-free telephonic nurse advice from trained and licensed registered nurses. The nurse advice line is available 24 hours a day, 7 days a week for assistance with health-related questions. You can reach the nurse advice line by calling Member Services for transfer to the nurse advice line.</p> </li> </ul>	<p>\$0 copay for the nurse advice line.*</p>



Covered Service	What you pay
<div> <b>Health and wellness education programs - continued</b></div> <div><ul style="list-style-type: none"><li><b>Fitness benefit</b> Our plan provides a fitness program that offers access to fitness locations nationwide.  To help support an active and healthy lifestyle you have access to the following features at no cost:<ul style="list-style-type: none"><li>Fitness Center Membership: Choose from a number of in-person fitness centers that participate in the fitness network. Membership includes access to standard fitness club or fitness studio services as well as group workout classes offered. You may access one or more gyms within the fitness network.</li><li>Home Fitness Kits: You may choose from a variety of home fitness kits, including a wearable fitness tracker. You can receive up to 1 kit per benefit year</li><li>Digital Fitness Program: Choose from thousands of on-demand workout videos through the digital library</li><li>1:1 Lifestyle Coaching program</li><li>Well-Being Club: Discover resources tailored to your interests and goals including articles, videos, and live-streaming classes and events</li></ul></li></ul><p>For more information regarding the fitness benefit, please call Member Services.</p></div>	<p>\$0 copay for the fitness benefit.*</p>
<div><b>Hearing services</b></div> <div>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</div>	<p>\$0 copay for each Medicare-covered hearing exam. <i>Prior Authorization may be required.</i></p>




**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Hearing services - continued</b></p> <p><b>Our plan also covers the following supplemental (i.e., routine) hearing services:</b></p> <ul style="list-style-type: none"> <li>1 routine hearing exam every year.</li> <li>1 hearing aid fitting and evaluation every year.</li> <li>1 non-implantable hearing aid up to \$500 per ear every year. Limited to 2 non-implantable hearing aids every year. Benefit includes a 3-year warranty including loss, and damage with a 1-year supply of batteries.</li> </ul> <p>Any hearing aid costs that exceed the benefit maximum above are your responsibility. Additional hearing aids are not covered.</p> <p><b>Routine hearing services must be received from a participating provider within the vendor network in order to receive the full hearing benefit covered by the plan.</b></p> <p>For more information on your hearing vendor, contact information and benefits, please call Member Services.</p> <p><b>Note:</b> Coverage of routine hearing services is a supplemental benefit offered by the plan. Neither Medicare nor Hawaii Med-QUEST Division Program (Medicaid) will pay your share of the cost for these services.</p>	<p>\$0 copay for 1 routine hearing exam every year.* <i>Prior Authorization may be required.</i></p> <p>\$0 copay for 1 hearing aid fitting and evaluation every year.* <i>Prior Authorization may be required.</i></p> <p>\$0 copay for 2 hearing aid(s) every year.* <i>Prior Authorization may be required.</i></p>
<p> <b>HIV screening</b></p> <p>For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> <li>One screening exam every 12 months.</li> </ul>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
 <b>HIV screening - continued</b>  If you are pregnant, we cover: <ul style="list-style-type: none"> <li>Up to 3 screening exams during a pregnancy.</li> </ul>	
<b>Home health agency care</b>  Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: <ul style="list-style-type: none"> <li>Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)</li> <li>Physical therapy, occupational therapy, and speech therapy</li> <li>Medical and social services</li> <li>Medical equipment and supplies</li> </ul>	\$0 copay for each Medicare-covered home health agency care service. <i>Prior Authorization may be required.</i>
<b>Home infusion therapy</b>  Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: <ul style="list-style-type: none"> <li>Professional services, including nursing services, furnished in accordance with our plan of care</li> <li>Patient training and education not otherwise covered under the durable medical equipment benefit</li> </ul>	\$0 copay for professional services from a Primary Care Provider (PCP), including nursing services, training and education, remote monitoring and monitoring services.  \$0 copay for professional services from a specialist, including nursing services, training and education, remote




Covered Service	What you pay
<p><b>Home infusion therapy - continued</b></p> <ul style="list-style-type: none"><li>• Remote monitoring</li><li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier</li></ul>	<p>monitoring and monitoring services. <i>Prior Authorization may be required.</i></p> <p>Home infusion equipment and supplies are covered under your Durable Medical Equipment (DME) benefit. Please see the “Durable medical equipment (DME) and related supplies” section for cost sharing information.</p> <p>Home infusion drugs are covered under your Medicare Part B Prescription Drugs benefit. Please see the “Medicare Part B Prescription Drugs” section for cost sharing information.</p>
<p><b>Hospice care</b></p> <p>You’re eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you’re terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan’s service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Drugs for symptom control and pain relief</li></ul>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.</p> <p>Physician service cost sharing may apply for hospice consultation services. See the “Physician/ Practitioner Services” section of this chart for information on cost sharing.</p>



Covered Service	What you pay
<p><b>Hospice care - continued</b></p> <ul style="list-style-type: none"><li>• Short-term respite care</li><li>• Home care</li></ul> <p>When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.</p> <p><b>For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:</b> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.</p> <p><b>For services covered by Medicare Part A or B not related to your terminal prognosis:</b> If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization).</p> <ul style="list-style-type: none"><li>• If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services</li><li>• If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare</li></ul> <p><b>For services covered by our plan but not covered by Medicare Part A or B:</b> Our plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.</p> <p><b>For drugs that may be covered by our plan's Part D benefit:</b> If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never</p>	



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Hospice care - continued</b></p> <p>covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4.</p> <p><b>Note:</b> If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
<p> <b>Immunizations</b></p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccines</li> <li>• Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary</li> <li>• Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B</li> <li>• COVID-19 vaccines</li> <li>• Other vaccines if you're at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We also cover most other adult vaccines under our Part D drug benefit.</p> <p>Our plan covers most adult Part D vaccines at no cost for members 19 years and older.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p> <p>For other Medicare-covered vaccines (if you are at risk and they meet Medicare Part B coverage rules), please refer to the Medicare Part B prescription drugs section of this chart for applicable cost sharing.</p> <p><i>Some Part B drugs require prior authorization to be covered.</i></p>
<p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the</p>	<p>For Medicare-covered admissions, per admission: \$0 copay for each hospital stay. Lifetime Reserve Days \$0 copay per day. Lifetime Reserve Days are additional days that the plan will pay for when members are</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Inpatient hospital care - continued</b></p> <p>hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p>You are covered for 90 days for Medicare-covered inpatient hospital stays.</p> <p>Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units (such as intensive care or coronary care units)</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Necessary surgical and medical supplies</li> <li>• Use of appliances, such as wheelchairs</li> <li>• Operating and recovery room costs</li> <li>• Physical, occupational, and speech language therapy</li> <li>• Inpatient substance abuse services</li> <li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion.</li> <li>• Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the first</li> </ul>	<p>in a hospital for more than the number of days covered by the plan. Members have a total of 60 reserve days that can be used during their lifetime. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p> <p><i>Prior Authorization may be required.</i></p>





Covered Service	What you pay
<p><b>Inpatient hospital care - continued</b></p> <p>pint of blood you need. All other components of blood are covered starting with the first pint.</p> <ul style="list-style-type: none"><li>Physician services</li></ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you’re not sure if you’re an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at <a href="https://www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	
<p><b>Inpatient services in a psychiatric hospital</b></p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>You are covered for 90 days per admission for Medicare-covered stays.</p> <p>There is a 190-day lifetime limit for inpatient mental health services provided in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. If you have used part of the 190-day Medicare lifetime benefit prior to enrolling in our plan, then you are only entitled to receive the remainder of your lifetime days.</p>	<p>For Medicare-covered admissions, per admission: \$0 copay for each mental health care stay.</p> <p>Lifetime Reserve Days \$0 copay per day. Lifetime Reserve Days are additional days that the plan will pay for when members are in a hospital for more than the number of days covered by the plan. Members have a total of 60 reserve days that can be used during their lifetime.</p> <p><i>Prior Authorization may be required.</i></p> <p>If you get authorized inpatient care at an out-of-network</p>



Covered Service	What you pay
<b>Inpatient services in a psychiatric hospital - continued</b>	hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.
<b>Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay</b>  If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: <ul style="list-style-type: none"><li>• Physician services</li><li>• Diagnostic tests (like lab tests)</li><li>• X-ray, radium, and isotope therapy including technician materials and services</li><li>• Surgical dressings</li><li>• Splints, casts, and other devices used to reduce fractures and dislocations</li><li>• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices</li><li>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition</li><li>• Physical therapy, speech therapy, and occupational therapy</li></ul>	The listed services will continue to be covered at the cost sharing amounts shown in the benefits chart for the specific service.




**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
 <b>Medical nutrition therapy</b>  <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>
 <b>Medicare Diabetes Prevention Program (MDPP)</b>  <p><b>MDPP services are covered for eligible people under all Medicare health plans.</b></p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p><b>Medicare Part B drugs</b></p> <p><b>These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:</b></p> <ul style="list-style-type: none"> <li>• Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services</li> <li>• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)</li> <li>• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan</li> <li>• The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional</li> </ul>	<p>Some drugs may be subject to step therapy.</p> <p>The pharmacy may need to submit claims to both our plan and Hawaii Med-QUEST Division Program (Medicaid) for you to receive Part B drugs at the cost shares shown below.</p> <p><b>Medicare Part B Insulin Drugs</b> \$0 copay for Medicare-covered Part B insulin drugs. Insulin cost sharing is subject to the lesser of 25% or a copay</p>



Covered Service	What you pay
<p><b>Medicare Part B drugs - continued</b></p> <p>scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment.</p> <ul style="list-style-type: none"><li>• Clotting factors you give yourself by injection if you have hemophilia</li><li>• Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them</li><li>• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug</li><li>• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision</li><li>• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does.</li><li>• Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug</li><li>• Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B</li></ul>	<p>cap of \$35 for one-month's supply of insulin. <i>Prior Authorization may be required.</i></p> <p><b>Other Medicare Part B Drugs</b> \$0 copay for other Medicare-covered Part B drugs. <i>Prior Authorization may be required.</i></p> <p><b>Medicare Part B Chemotherapy/ Radiation Drugs</b> \$0 copay for Medicare-covered Part B chemotherapy drugs. <i>Prior Authorization may be required.</i></p>



Covered Service	What you pay
<div><b>Medicare Part B drugs - continued</b></div> <div><ul style="list-style-type: none"><li>• Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®</li><li>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics</li><li>• Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta)</li><li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li><li>• Parenteral and enteral nutrition (intravenous and tube feeding)</li></ul><p>This link will take you to a list of Part B drugs that may be subject to Step Therapy: <a href="https://go.wellcare.com/HIStepTherapy">go.wellcare.com/HIStepTherapy</a>.</p><p>We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit.</p><p>Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.</p></div>	
<div> <b>Obesity screening and therapy to promote sustained weight loss</b></div> <div><p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p></div>	<div>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</div>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Opioid treatment program services</b></p> <p>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> <li>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications</li> <li>• Dispensing and administration of MAT medications (if applicable)</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Toxicology testing</li> <li>• Intake activities</li> <li>• Periodic assessments</li> </ul>	<p>\$0 copay for each Medicare-covered opioid treatment service. <i>Prior Authorization may be required.</i></p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts, and other devices used to reduce fractures and dislocations</li> </ul>	<p>\$0 copay for Medicare-covered X-rays. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered therapeutic radiology services. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered medical supplies including casts and splints. <i>Prior Authorization may be required.</i></p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Outpatient diagnostic tests and therapeutic services and supplies - continued</b></p> <ul style="list-style-type: none"> <li>Laboratory tests</li> <li>Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used</li> <li>Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.</li> <li>Other outpatient diagnostic tests</li> </ul>	<p>\$0 copay for each Medicare-covered lab services. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered blood services.</p> <p>\$0 copay for Medicare-covered diagnostic radiology services. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered diagnostic procedures and tests. <i>Prior Authorization may be required.</i></p>
<p><b>Outpatient hospital observation</b></p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p>	<p>\$0 copay for each Medicare-covered observation service visit.</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Outpatient hospital observation - continued</b></p> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at <a href="https://www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	
<p><b>Outpatient hospital services</b></p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</li> <li>• Laboratory and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> <li>• Certain drugs and biologicals you can't give yourself</li> </ul> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.</p>	<p>You pay the applicable cost sharing amounts shown in this Medical Benefits Chart for the specific service.</p>



Chapter 4 Medical Benefits Chart (what’s covered)

Covered Service	What you pay
<p><b>Outpatient mental health care</b></p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <ul style="list-style-type: none"><li>Services provided by a psychiatrist</li></ul>	<p>\$0 copay for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>\$0 copay for each Medicare-covered group therapy visit with a psychiatrist.</p> <p><i>Prior Authorization may be required.</i></p>
<ul style="list-style-type: none"><li>Services provided by other mental health care providers</li></ul>	<p>\$0 copay for each Medicare-covered individual therapy visit with other mental health care providers.</p> <p>\$0 copay for each Medicare-covered group therapy visit with other mental health care providers.</p> <p><i>Prior Authorization may be required.</i></p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Outpatient rehabilitation services</b></p> <p>Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p> <ul style="list-style-type: none"> <li>• Services provided by a physical therapist</li> <li>• Services provided by an occupational therapist</li> <li>• Services provided by a speech language therapist</li> </ul>	<p>\$0 copay for each Medicare-covered physical therapy visit. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for each Medicare-covered occupational therapy visit. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for each Medicare-covered speech language therapy visit. <i>Prior Authorization may be required.</i></p>
<p><b>Outpatient substance use disorder services</b></p> <p>Covered services include:</p> <p>Substance Use Disorder services such as individual and group therapy sessions provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional or program, as allowed under applicable state laws.</p>	<p>\$0 copay for each Medicare-covered individual therapy visit.</p> <p>\$0 copay for each Medicare-covered group therapy visit.</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<b>Outpatient substance use disorder services - continued</b>	<i>Prior Authorization may be required.</i>
<b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</b>  <b>Note:</b> If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. <ul style="list-style-type: none"> <li>Services provided at an outpatient hospital</li> <li>Services provided at an ambulatory surgical center</li> </ul>	<p>\$0 copay for each Medicare-covered visit to an outpatient hospital facility. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for each Medicare-covered visit to an ambulatory surgical center. <i>Prior Authorization may be required.</i></p>
<b>Partial hospitalization services and Intensive outpatient services</b>  <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	<p>\$0 copay per day for each Medicare-covered partial hospitalization service. <i>Prior Authorization may be required.</i></p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Partial hospitalization services and Intensive outpatient services - continued</b></p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p>	<p>\$0 copay per day for each Medicare-covered intensive outpatient service. <i>Prior Authorization may be required.</i></p>
<p><b>Physician/Practitioner services, including doctor's office visits</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> <li>Consultation, diagnosis, and treatment by a specialist</li> <li>Other health care professionals</li> </ul>	<p>\$0 copay for each Medicare-covered PCP office visit.</p> <p>See "Outpatient Surgery" earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting.</p> <p>\$0 copay for each Medicare-covered specialist visit. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for each visit to other health care professionals. <i>Prior Authorization may be required.</i></p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Physician/Practitioner services, including doctor's office visits - continued</b></p> <ul style="list-style-type: none"> <li>• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment</li> <li>• Certain telehealth services, including: Urgently Needed Services, Home Health Services, Primary Care Physician, Occupational Therapy, Specialist, Individual and Group Sessions for Mental Health, Podiatry Services, Other Health Care Professional, Individual and Group Sessions for Psychiatric, Physical Therapy and Speech-Language Pathology Services, Individual and Group Sessions for Outpatient Substance Abuse, and Diabetes Self-Management Training. <ul style="list-style-type: none"> <li>○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.</li> <li>○ A virtual visit (also known as telehealth or telemedicine) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.</li> <li>○ Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors through virtual visit network providers to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more. For more information, or to find a virtual visit network provider call Member Services.</li> </ul> </li> </ul>	<p>\$0 copay for Medicare-covered hearing services. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for virtual visit services performed through your plan's virtual visit provider(s).</p> <p><b>Please note:</b> The \$0 copay above, only applies when services are received from your plan's virtual visit provider(s). If you receive in-person or telemedicine services from a network provider and not the virtual visit provider(s), you will pay the cost shares listed for those providers, as outlined within this benefit chart (e.g., if you receive telehealth services from your PCP, you will pay the PCP cost share).</p>




Covered Service	What you pay
<p><b>Physician/Practitioner services, including doctor’s office visits - continued</b></p> <ul style="list-style-type: none"><li>• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare</li><li>• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member’s home</li><li>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location</li><li>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location</li><li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders <b>if</b>:<ul style="list-style-type: none"><li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li><li>○ You have an in-person visit every 12 months while getting these telehealth services</li><li>○ Exceptions can be made to the above for certain circumstances</li></ul></li><li>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers</li><li>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b>:<ul style="list-style-type: none"><li>○ You’re not a new patient <b>and</b></li><li>○ The check-in isn’t related to an office visit in the past 7 days <b>and</b></li><li>○ The check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment</li></ul></li></ul>	<p>You will pay the cost sharing that applies to the provider (as described under “Physician/Practitioner Services, Including Doctor’s Office Visits” above).</p>



Covered Service	What you pay
<p><b>Physician/Practitioner services, including doctor's office visits - continued</b></p> <ul style="list-style-type: none"><li>Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours <b>if</b>:<ul style="list-style-type: none"><li>You're not a new patient <b>and</b></li><li>The evaluation isn't related to an office visit in the past 7 days <b>and</b></li><li>The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li></ul></li><li>Consultation your doctor has with other doctors by phone, internet, or electronic health record</li><li>Second opinion by another network provider prior to surgery</li></ul>	<p>You will pay the cost sharing that applies to the provider (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p> <p>You will pay the cost sharing that applies to the provider (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p> <p>You will pay the cost sharing that applies to the provider (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p> <p>In addition to the cost shares above, there will be a copay and/or coinsurance for Medically Necessary Medicare-covered Services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, eyeglasses and contacts after cataract surgery, Part D</p>




**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<b>Physician/Practitioner services, including doctor's office visits - continued</b>	<p>prescription drugs and Medicare Part B prescription drugs, as described in this Benefit Chart.</p>
<b>Podiatry services</b>  Covered services include: <ul style="list-style-type: none"> <li>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs</li> </ul>	<p>\$0 copay for Medicare-covered podiatry services. <i>Prior Authorization may be required.</i></p>
 <b>Pre-exposure prophylaxis (PrEP) for HIV prevention</b>  If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.  If you qualify, covered services include: <ul style="list-style-type: none"> <li>• FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug.</li> <li>• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.</li> <li>• Up to 8 HIV screenings every 12 months.</li> </ul> A one-time hepatitis B virus screening.	<p>There is no coinsurance, copayment, or deductible for the PrEP benefit.</p>





**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
 <b>Prostate cancer screening exams</b>  For men aged 50 and older, covered services include the following once every 12 months: <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>\$0 copay for each Medicare-covered annual digital rectal exam.</p> <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>
<b>Prosthetic and orthotic devices and related supplies</b>  Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.	<p>\$0 copay for Medicare-covered prosthetic or orthotics. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered medical supplies related to prosthetic devices. <i>Prior Authorization may be required.</i></p>
<b>Pulmonary rehabilitation services</b>  Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	<p>\$0 copay for each Medicare-covered pulmonary rehabilitation services visit.</p>





**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
 <b>Screening and counseling to reduce alcohol misuse</b>  <p>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
 <b>Screening for lung cancer with low dose computed tomography (LDCT)</b>  <p>For qualified people, a LDCT is covered every 12 months.</p> <p><b>Eligible members are</b> people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
 <b>Screening for Hepatitis C Virus infection</b> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> <li>• You're at high risk because you use or have used illicit injection drugs.</li> <li>• You had a blood transfusion before 1992.</li> <li>• You were born between 1945-1965.</li> </ul> <p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.</p>
 <b>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</b> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Services to treat kidney disease</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime</li> <li>Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)</li> <li>Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)</li> <li>Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>Home dialysis equipment and supplies</li> <li>Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</li> </ul>	<p>\$0 copay for Medicare-covered kidney disease education services.</p> <p>\$0 copay for Medicare-covered outpatient renal dialysis treatments.</p> <p>See "Inpatient Hospital Care" for cost shares applicable to inpatient dialysis treatments.</p> <p>\$0 copay for Medicare-covered self-dialysis training.</p> <p>\$0 copay for Medicare-covered home dialysis equipment. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered dialysis supplies. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered home support services.</p>




**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Services to treat kidney disease - continued</b></p> <p>Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to <b>Medicare Part B drugs</b> in this table.</p>	
<p><b>Skilled nursing facility (SNF) care</b></p> <p>(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)</p> <p>Up to 100 days per benefit period of confinement and skilled care services in SNF or alternate setting are covered services when such services meet the Plan's and Medicare coverage guidelines. No prior hospital stay is required. The 100-day per benefit period includes SNF days received through the Plan, Original Medicare or any other Medicare Advantage Organization during the benefit period.</p> <p>Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Skilled nursing services</li> <li>• Physical therapy, occupational therapy and speech therapy</li> <li>• Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)</li> <li>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood you need. All other components of blood are covered beginning with the first pint used.</li> <li>• Medical and surgical supplies ordinarily provided by SNFs</li> <li>• Laboratory tests ordinarily provided by SNFs</li> <li>• X-rays and other radiology services ordinarily provided by SNFs</li> <li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li> </ul>	<p>For Medicare-covered admissions, per benefit period: \$0 copay for each Medicare-covered skilled nursing facility stay.</p> <p>You pay all costs for each day after day 100.</p> <p><i>Prior Authorization may be required.</i></p> <p>A benefit period begins the first day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Skilled nursing facility (SNF) care - continued</b></p> <ul style="list-style-type: none"> <li>Physician/Practitioner services</li> </ul> <p>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> <li>A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)</li> <li>A SNF where your spouse or domestic partner is living at the time you leave the hospital</li> </ul>	
<p> <b>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</b></p> <p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> <li>Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease</li> <li>Are competent and alert during counseling</li> <li>A qualified physician or other Medicare-recognized practitioner provides counseling</li> </ul> <p>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p><b>Social support platform</b></p> <p>Our plan provides an online social support platform to help support your overall well-being. The platform offers community engagement, therapeutic activities, and plan-sponsored resources to help manage stress and anxiety. The platform makes it easy for you to participate and remain involved to assist you in managing your behavioral health needs. It is available online 24/7, so you can use it whenever you choose.</p>	<p>\$0 copay for the social support platform.*</p>



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Social support platform - continued</b></p> <p>The social support platform includes:</p> <ul style="list-style-type: none"> <li>• Tailored Well-Being Programs: Access customized 4-week self-guided programs designed to enhance physical and emotional well-being, incorporating insights from healthy aging experts to specifically support members. Follow programs at your own pace and track your progress to monitor improvements in your health.</li> <li>• Peer and Expert Support: Connect with an online community in a moderated space where you can interact with peers and qualified health experts. Obtain access to clinically reviewed articles and receive personalized recommendations for additional Wellcare services based on your interactions and identified needs.</li> <li>• Personalized Digital Health Tools: Engage in interactive activities, meditations, and games grounded in cognitive behavioral therapy, mindfulness, and positive psychology. These tools address topics such as healthy aging, managing isolation, caregiving, grief, finding purpose in aging, and more.</li> </ul> <p>Members can access the platform by logging into their member portal at <a href="https://go.wellcare.com/member">go.wellcare.com/member</a> or by calling Member Services. After you register, you can access the platform directly at any time from a computer, tablet, or smartphone.</p>	
<p><b>Special Supplemental Benefits for the Chronically Ill</b></p> <p>If you qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI), our plan offers additional benefits. You must meet certain criteria, including having a documented and active diagnosis for one or more qualifying conditions. The condition must be life threatening or greatly limit your overall health or function. Additionally, you must need intensive care management and be at high risk for unplanned hospitalization. Qualifying chronic conditions include:</p> <p>Autoimmune disorders (includes Rheumatoid arthritis); Cancer; Cardiovascular disorders (includes Hypertension);</p>	<p>There is no coinsurance, copayment, or deductible for Special Supplemental Benefits for the Chronically Ill.</p>



Covered Service	What you pay
<p><b>Special Supplemental Benefits for the Chronically Ill - continued</b></p> <p>Chronic alcohol use disorder and other substance use disorders (SUDs); Chronic Heart Failure; Chronic lung disorders; Chronic and disabling mental health conditions; Chronic gastrointestinal disease (includes Chronic gastrointestinal disorders); Chronic kidney disease (CKD); Conditions with functional challenges (includes End Stage Renal Disease (ESRD), End Stage Liver Disease, Osteoporosis (bone disease), Osteoarthritis); Conditions that require continued therapy services in order for individuals to maintain or retain functioning (includes Muscular Dystrophy); Conditions associated with cognitive impairment (includes Down Syndrome); Dementia; Diabetes mellitus; HIV/AIDS; Endometriosis; Neurologic disorders; Severe hematologic disorders; Overweight, obesity, and metabolic syndrome (includes Hyperlipidemia/Dyslipidemia); Post-organ transplantation; Stroke</p> <p>Refer to Chapter 4, Section 2 for more information about eligibility criteria. Eligibility for the benefits below is determined after you enroll in our plan.</p> <p><b>If eligible, you have the option to utilize your Wellcare Spendables® allowance towards the additional benefits listed below. Once determined eligible these expanded benefits will be available in 7-10 business days. Allowance carries over to the following month if unused and expires at the end of the plan year. Refer to the Wellcare Spendables® benefit in this chart for more information.</b></p> <ul style="list-style-type: none"><li><b>Gas pay-at-pump</b> You can use your card to pay for gas directly at the pump at participating locations. The card cannot be used for payment in person at the cash register. Your card can only be used to pump gas up to the available allowance amount.</li><li><b>Healthy Food</b> You can use your card for healthy foods and produce at</li></ul>	



Covered Service	What you pay
<p><b>Special Supplemental Benefits for the Chronically Ill - continued</b></p> <p>participating retailers. Delivery options for eligible grocery items may be available. Prepared meals and produce boxes are available for order via online portal. The card cannot be used to buy tobacco or alcohol. Approved items include:</p> <ul style="list-style-type: none"><li>○ Meat and poultry</li><li>○ Fruits and vegetables</li><li>○ Nutritional drinks</li></ul> <p>Use your in-app barcode scanner to locate approved items at retail locations, log in to your member portal or refer to your catalog.</p> <ul style="list-style-type: none"><li>• <b>Home Assistance and Safety Items</b> You can use your card to help with the cost of home assistance and safety items, including installation services for eligible products. Log in to your member portal or contact us to purchase accepted items and view eligible services. Approved items and services include:<ul style="list-style-type: none"><li>○ Grab bars or doorknobs and non-slip floor coverings</li><li>○ Safety chairs and bathroom modification aids</li><li>○ Portable air conditioning and air quality products</li><li>○ Pest and insect control supplies and in-home treatments</li></ul></li><li>• <b>Rent Assistance</b> You can use your card to help with the cost of rent for your home. Log in to your rent/mortgage provider portal to pay or pay your rent provider directly where card payments are accepted. Your card can only be used up to the available</li></ul>	




**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Special Supplemental Benefits for the Chronically Ill - continued</b></p> <p>allowance amount. The card cannot be used to set up automatic recurring payments.</p> <ul style="list-style-type: none"> <li>• <b>Utility Assistance</b></li> </ul> <p>You can use your card to help with the cost of utilities for your home. Log in direct to your utilities provider portal and pay using your card. The card cannot be used to set up automatic recurring payments. Your card can only be used up to the available allowance amount. Approved expenses for this benefit include:</p> <ul style="list-style-type: none"> <li>○ Electric, gas, sanitation/trash, and water utility services</li> <li>○ Landline and cell phone service</li> <li>○ Internet service</li> <li>○ Cable TV service (excludes streaming services)</li> <li>○ Certain petroleum expenses, such as home heating oil</li> </ul>	
<p><b>Supervised Exercise Therapy (SET)</b></p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD).</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> <li>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication</li> <li>• Be conducted in a hospital outpatient setting or a physician's office</li> <li>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD</li> </ul>	<p>\$0 copay for each Medicare-covered supervised exercise therapy visit.</p>




Covered Service	What you pay
<p><b>Supervised Exercise Therapy (SET) - continued</b></p> <ul style="list-style-type: none"><li>Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques</li></ul> <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	
<p><b>Urgently needed services</b></p> <p>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.</p> <p>Urgently needed services outside the United States are covered.</p>	<p>\$0 copay for Medicare-covered urgently needed service visits.</p> <p>\$115 copay for urgently needed services outside of the United States.* You pay this amount even if you are admitted to the hospital within 24 hours for the same condition. You are covered for up to \$50,000 every year for emergency or urgently needed services outside the United States.</p>



Covered Service	What you pay
<div> <b>Vision care</b></div> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.</li><li>• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older.</li><li>• For people with diabetes, screening for diabetic retinopathy is covered once per year</li><li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.</li></ul> <p><b>In addition, our plan covers the following supplemental (i.e., routine) vision services:</b></p> <ul style="list-style-type: none"><li>• 1 routine eye exam every year. The routine eye exam includes a glaucoma test for people who are at risk for glaucoma and a retinal exam for diabetics.</li></ul>	<p>\$0 copay for all other eye exams to diagnose and treat diseases of the eye. <i>Prior Authorization may be required.</i></p> <p>\$0 copay for a Medicare-covered glaucoma screening.</p> <p>\$0 copay for Medicare-covered retinal exam for diabetic members or diabetic eye exam.</p> <p><i>Prior Authorization may be required.</i></p> <p>\$0 copay for Medicare-covered eyewear.</p> <p>\$0 copay for 1 routine eye exam every year.*</p>



Covered Service	What you pay
<div> <b>Vision care - continued</b></div> <div><ul style="list-style-type: none"><li>Unlimited pairs of prescription eyewear every year up to a maximum benefit of \$100 every year. Covered eyewear includes any of the following:<ul style="list-style-type: none"><li>Eyeglasses (frame and lenses) or</li><li>Eyeglass lenses only or</li><li>Eyeglass frames only or</li><li>Contact lenses instead of eyeglasses or</li><li>Vision hardware upgrades</li></ul></li></ul></div> <div><p><b>Note:</b> Contact lenses fitting fee is covered by the plan.</p><p>Maximum plan benefit coverage amount of \$100 every year applies to the retail cost of frames and/or lenses (including any lens options such as tints and coatings). You are responsible for any costs above the benefit maximum for supplemental (i.e., routine) eyewear.*</p><p>Medicare-covered eyewear is not included in the supplemental (i.e., routine) benefit maximum. Members cannot use their supplemental eyewear benefit to increase their coverage on Medicare-covered eyewear.</p><p><b>Note:</b> Coverage of routine vision services is a supplemental benefit offered by the plan. Neither Medicare nor Hawaii Med-QUEST Division Program (Medicaid) will pay your share of the cost for these services.</p><p>Vision services must be obtained through the plan’s vision network. For questions on how to find a provider or for more information call Member Services.</p></div>	<div><p><i>Prior Authorization may be required.</i></p><p><i>\$0 copay for eyewear.*</i></p><p><i>Prior Authorization may be required.</i></p></div>







Covered Service	What you pay
<p><b>Wellcare Spendables® - continued</b></p> <p><b>Note:</b> Under certain circumstances diagnostic equipment and smoking-cessation aids are covered under the plan’s medical benefits. You should (when possible) use our plan’s medical benefits prior to spending your OTC allowance on these items.</p> <p><b>Dental, Vision, and Hearing</b></p> <p>You may use your card to help reduce your out-of-pocket expenses for dental, vision, and hearing services. The card may be used to pay your dental, vision, or hearing provider directly.</p> <ul style="list-style-type: none"><li>• All purchases and transactions must be placed within a provider office or provider location.</li><li>• The allowance cannot be used for cosmetic or aesthetic services, nitrous oxide, intravenous sedation, teeth whitening, or bleaching.</li></ul> <p><b>Your card may be used for the following:</b></p> <p><b>Dental</b></p> <p>This allowance is not a replacement of your routine dental benefit. You should use our plan’s benefit prior to using your Spendables allowance.</p> <ul style="list-style-type: none"><li>• Other Diagnostic Dental Services</li><li>• Other Preventive Dental Services</li><li>• Restorative Services</li><li>• Endodontics</li><li>• Periodontics</li><li>• Prosthodontics, removable</li><li>• Prosthodontics, fixed</li><li>• Oral and Maxillofacial Surgery</li><li>• Adjunctive General Services</li></ul> <p><b>Vision</b></p> <p>This allowance is not a replacement of your routine vision benefit. You should use our plan’s benefit prior to using your Spendables allowance.</p> <ul style="list-style-type: none"><li>• Routine eye exam</li><li>• Contact lenses</li><li>• Eyeglasses (lenses and frames)</li><li>• Eyeglass lenses</li></ul>	



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Wellcare Spendables® - continued</b></p> <ul style="list-style-type: none"> <li>• Eyeglass Frames</li> <li>• Upgrades</li> </ul> <p><b>Hearing</b> This allowance is not a replacement of your routine hearing benefit. You should use our plan's benefit prior to using your Spendables allowance.</p> <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Fitting/evaluation for hearing aid</li> <li>• Prescription Hearing Aids (all types)</li> </ul> <p><b><u>Benefits mentioned below are part of SSBCI. Not all members will qualify. You must meet eligibility criteria for the following plan benefits.</u></b></p> <p><b><u>If you qualify, your monthly card allowance can also be used towards:</u></b></p> <ul style="list-style-type: none"> <li>• Gas pay-at-pump</li> <li>• Healthy Food</li> <li>• Home Assistance and Safety Items</li> <li>• Pest Control Services and Items</li> <li>• Rent Assistance</li> <li>• Utility Assistance</li> </ul> <p>Refer to the Special Supplemental Benefits for the Chronically Ill (SSBCI) benefit in this chart for more information on these benefits.</p> <p><b><u>How to use your card:</u></b></p> <ol style="list-style-type: none"> <li>1. Activate your card before you use it.</li> <li>2. Visit a participating retailer, log into the portal link listed below, or download the Wellcare Spendables® mobile app.</li> <li>3. Select your approved items/services.</li> <li>4. In store, proceed to the retailer's checkout and pay with your Wellcare Spendables® card. For online or mobile app orders, log in to access and use your benefit.</li> <li>5. Your card is not a credit card but may be entered as 'credit' to checkout. If prompted, enter the PIN you created when you activated your card.</li> </ol>	



**Chapter 4 Medical Benefits Chart (what's covered)**

Covered Service	What you pay
<p><b>Wellcare Spendables® - continued</b></p> <p><b>Additional information you should know:</b></p> <ul style="list-style-type: none"> <li>• Once you've used your spending allowance, you are responsible for the remaining cost of your purchases.</li> <li>• Items purchased in store may be returned following the retailers return and exchange policies.</li> <li>• If your card is not functioning properly or in the event of a technical issue, please contact us at the number below.</li> <li>• Wellcare is not responsible for lost or stolen cards.</li> <li>• The Wellcare Spendables® card is only for your personal use, cannot be sold or transferred, and has no cash value.</li> <li>• Select rent and utilities services may be eligible for reimbursement if payment is unsuccessful. Contact us or submit a reimbursement request through the member portal for review. Reimbursements must be submitted within 120 days of date of transaction and must be within the same plan year.</li> <li>• Limitations and restrictions may apply, only approved items are covered.</li> <li>• This is not a Hawaii Med-QUEST Division Program (Medicaid) benefit.</li> </ul> <p><b>For more information about the Wellcare Spendables® card or to request a catalog, please call:</b> 1-888-846-4262, TTY users call: 711.</p> <p>Hours are: Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.</p> <p><b>You can also visit online at:</b> <a href="https://go.wellcare.com/member">go.wellcare.com/member</a>.</p>	

**SECTION 3 Services covered outside of the plan**

**The following services are covered by Hawaii Med-QUEST Division Program (Medicaid) Fee for Service:**

- State of Hawaii Organ and Tissue Transplant Program



- Services for Individuals with Intellectual and Developmental Disabilities
- Dental Services
- Intentional Termination of Pregnancies (ITOPs)

SECTION 4    Services that aren’t covered by our plan (exclusions)

This section tells you what services are excluded.

The chart below lists services and items that aren’t covered by our plan under any conditions or are covered by our plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3.)

Services not covered by Medicare	Covered only under specific conditions
<b>Cosmetic surgery or procedures</b>	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member  Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
<b>Custodial care</b>  Custodial care is personal care that doesn’t require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition



**Chapter 4 Medical Benefits Chart (what's covered)**

Services not covered by Medicare	Covered only under specific conditions
<b>Experimental medical and surgical procedures, equipment, and medications</b>  Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare- approved clinical research study or by our plan  (Go to Chapter 3, Section 5 for more information on clinical research studies)
<b>Fees charged for care by your immediate relatives or members of your household</b>	Not covered under any condition
<b>Full-time nursing care in your home</b>	Not covered under any condition
<b>Home-delivered meals</b>	See the 'Healthy Food' benefit in the SSBCI section of the Medical Benefits Chart for more information
<b>Homemaker services include basic household help, including light housekeeping or light meal preparation.</b>	Not covered under any condition
<b>Naturopath services (uses natural or alternative treatments)</b>	Not covered under any condition
<b>Orthopedic shoes or supportive devices for the feet</b>	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
<b>Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television</b>	Not covered under any condition
<b>Private room in a hospital</b>	Covered only when medically necessary
<b>Reversal of sterilization procedures and/or non-prescription contraceptive supplies</b>	Not covered under any condition



**Chapter 4 Medical Benefits Chart (what's covered)**

Services not covered by Medicare	Covered only under specific conditions
<b>Routine dental care, such as:</b> <ul style="list-style-type: none"> <li>• <b>Cleanings (Prophylaxis)</b></li> <li>• <b>Fluoride treatment</b></li> <li>• <b>Orthodontic services</b></li> <li>• <b>Implant services</b></li> <li>• <b>Maxillofacial prosthetics</b></li> </ul>	Not covered under any condition See the Dental care services benefit in the Medical Benefits Chart for routine dental care your plan covers as part of your benefit package
<b>Routine foot care (podiatry)</b>	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
<b>Services considered not reasonable and necessary, according to Original Medicare standards</b>	Not covered under any condition
<b>Vision Care: Radial keratotomy, LASIK surgery, and other low vision aids</b>	Not covered under any condition
<b>Vision Care: Routine eye examinations, eyeglasses</b>	See the Vision care benefit in the Medical Benefits Chart for routine vision services your plan covers as part of your benefit package.



## CHAPTER 5:

# Using plan coverage for Part D drugs

---

### How can you get information about your drug costs?

Because you're eligible for Hawaii Med-QUEST Division Program (Medicaid), you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-888-846-4262 (TTY users call 711) and ask for the *LIS Rider*. (Phone numbers for Member Services are printed on the back cover of this document.)

### SECTION 1 Basic rules for our plan's Part D drug coverage

---

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Hawaii Med-QUEST Division Program (Medicaid) benefits.

To find out more about Medicaid's drug coverage please contact Hawaii Med-QUEST Division Program (Medicaid) to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Hawaii Med-QUEST Division Program (Medicaid) in Chapter 2, Section 6.)

Our plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) *or you can fill your prescription through our plan's mail-order service.*
- Your drug must be on our plan's Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)



## Chapter 5 Using plan coverage for Part D drugs

---

- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information)

### SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service

---

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term "covered drugs" means all the Part D drugs on our plan's Drug List.

#### Section 2.1 Network pharmacies

##### Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider & Pharmacy Directory*, visit our website ([go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories)), and/or call Member Services at 1-888-846-4262 (TTY users call 711).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider & Pharmacy Directory* will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

##### If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, get help from Member Services at 1-888-846-4262 (TTY users call 711) or use the *Provider & Pharmacy Directory*. You can also find information on our website at [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories).

##### Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Member Services at 1-888-846-4262 (TTY users call 711).



## Chapter 5 Using plan coverage for Part D drugs

---

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Provider & Pharmacy Directory* [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories) or call Member Services at 1-888-846-4262 (TTY users call 711).

### Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs that aren't available through our plan's mail-order service are marked as “**NM**” in our Drug List.

Our plan's mail-order service allows you to order **at least a 35-day supply of the drug and no more than a 100-day supply**.

To get order forms and information about filling your prescriptions by mail, call Express Scripts® Pharmacy at 1-833-750-0201 (TTY: 711) 24 hours a day, 7 days a week. Or, log on to [express-scripts.com/rx](https://express-scripts.com/rx). If you use a mail order pharmacy not in the plan's network, your prescription will not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. However, sometimes your mail order prescription may be delayed. For long-term medications that you need right away, ask your doctor for two prescriptions: one for a 30-day supply to fill at a participating retail pharmacy, and one for a long-term (35 to 100-day) supply to fill through the mail. If you have any problem with getting your 30-day supply filled at a participating retail pharmacy when your mail order prescription is delayed, please have your retail pharmacy call our Provider Service Center at 1-866-800-6111 (TTY 1-888-816-5252), 24 hours a day, 7 days a week for assistance. Members can call Express Scripts® Pharmacy at 1-833-750-0201 (TTY: 711), 24 hours a day, 7 days a week. Or, log on to [express-scripts.com/rx](https://express-scripts.com/rx).

#### **New prescriptions the pharmacy gets directly from your doctor's office.**

The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time by calling Express Scripts® Pharmacy at 1-833-750-0201, (TTY: 711), 24 hours a day, 7 days a week. Or, log on to [express-scripts.com/rx](https://express-scripts.com/rx).

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.



## Chapter 5 Using plan coverage for Part D drugs

---

If you used mail order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Express Scripts® Pharmacy at 1-833-750-0201, (TTY: 711), 24 hours a day, 7 days a week. Or, log on to [express-scripts.com/rx](https://express-scripts.com/rx).

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by calling Express Scripts® Pharmacy at 1-833-750-0201, (TTY: 711), 24 hours a day, 7 days a week. Or, log on to [express-scripts.com/rx](https://express-scripts.com/rx).

**Refills on mail-order prescriptions.** For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 21 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling your mail order pharmacy:

- **Express Scripts® Pharmacy: 1-833-750-0201 (TTY users can call 711).**

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

### Section 2.3 How to get a long-term supply of drugs

Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider & Pharmacy Directory* [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 1-888-846-4262 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.



## Chapter 5 Using plan coverage for Part D drugs

---

### Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services at 1-888-846-4262 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

**Travel:** Getting coverage when you travel or are away from the plan's service area.

- If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through a mail order pharmacy.
- If you are traveling within the United States and territories and become ill, or lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a reimbursement form. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. To learn how to submit a reimbursement claim, please refer to Chapter 7, Section 2.
- You can also call Member Services to find out if there is a network pharmacy in the area where you are traveling.
- We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and territories, even for a medical emergency.

**Medical Emergency:** What if I need a prescription because of a medical emergency or because I needed urgent care?

- We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgent care. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a reimbursement form. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. To learn how to submit a reimbursement claim, please refer to Chapter 7, Section 2.

**Additional Situations:** Other times you can get your prescription covered if you go to an out-of-network pharmacy.



## Chapter 5 Using plan coverage for Part D drugs

---

- We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:
  - If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy, within a reasonable driving distance, that provides 24-hour service.
  - If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (including high-cost and unique drugs).
  - If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and is administered in your doctor's office.
  - If you get a covered prescription drug from an institutional based pharmacy while a patient in an outpatient surgery clinic, or other outpatient setting.
- For all of the above-listed situations, you may receive up to a 30-day supply of prescription drugs. In addition, you will likely have to pay the out-of-network pharmacy's charge for the drug and submit documentation to receive reimbursement from our plan. Please be sure to include an explanation of the situation concerning why you used a pharmacy outside of our network. This will help with the processing of your reimbursement request.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

### SECTION 3 Your drugs need to be on our plan's Drug List

---

#### Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. To find out more about Medicaid's drug coverage please contact Hawaii Med-QUEST Division Program (Medicaid) to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Hawaii Med-QUEST Division Program (Medicaid) in Chapter 2, Section 6.)

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that's *either*:



## Chapter 5 Using plan coverage for Part D drugs

---

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

### Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that isn't on our Drug List. (For more information, go to Chapter 9.)
- Prescription drugs covered by Hawaii Med-QUEST Division Program (Medicaid) are not on the Drug List. Please contact Hawaii Med-QUEST Division Program (Medicaid) to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Hawaii Med-QUEST Division Program (Medicaid) in Chapter 2, Section 6.)

### Section 3.2 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website ([go.wellcare.com/OhanaHI](https://go.wellcare.com/OhanaHI)). The Drug List on the website is always the most current.



## Chapter 5 Using plan coverage for Part D drugs

---

- Call Member Services at 1-888-846-4262 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" ([go.wellcare.com/OhanaHI](https://go.wellcare.com/OhanaHI)) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-888-846-4262 (TTY users call 711).

## SECTION 4 Drugs with restrictions on coverage

---

### Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

### Section 4.2 Types of restrictions

**If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug.** Call Member Services at 1-888-846-4262 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

#### Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-888-846-4262 (TTY users call 711) or on our website [go.wellcare.com/pa-select](https://go.wellcare.com/pa-select).



## Chapter 5 Using plan coverage for Part D drugs

---

### Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 1-888-846-4262 (TTY users call 711) or on our website [go.wellcare.com/st-select](https://go.wellcare.com/st-select).

### Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

## SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

---

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.

### If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

### You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way**.

- **If you're a new member**, we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.



## Chapter 5 Using plan coverage for Part D drugs

---

- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of a 30 day supply at a retail pharmacy, or a 31-day supply at a long-term care pharmacy. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply at a retail pharmacy, or a 31-day supply at a long-term care pharmacy of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:**

We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- **For those members who experience a level of care change (such as moving to or from a long-term care facility or hospital) and need a supply right away:**

We will cover one 30-day supply, or less if your prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 30-day supply of medication).

For questions about a temporary supply, call Member Services at 1-888-846-4262 (TTY users call 711).

**During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:**

### **Option 1. You can change to another drug**

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-888-846-4262 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

### **Option 2. You can ask for an exception**

**You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered.** If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it's not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

**If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do.** It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.



## Chapter 5 Using plan coverage for Part D drugs

---

### SECTION 6 Our Drug List can change during the year

---

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's Drug List.

#### Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes were made for a drug that you take.

#### Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - We may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be with the same or fewer restrictions.



## Chapter 5 Using plan coverage for Part D drugs

---

- We'll make these changes only if we add a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
- We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you take.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or ask for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

### Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.



## Chapter 5 Using plan coverage for Part D drugs

---

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

### SECTION 7 Types of drugs we don't cover

---

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Hawaii Med-QUEST Division Program (Medicaid), you must pay for it yourself.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare or Medicaid. However, some of these drugs may be covered for you under your Hawaii Med-QUEST Division Program (Medicaid) drug coverage. Please contact Hawaii Med-QUEST Division Program (Medicaid) to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Hawaii Med-QUEST Division Program (Medicaid) in Chapter 2, Section 6.)

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale



## Chapter 5 Using plan coverage for Part D drugs

---

**If you get Extra Help** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

### SECTION 8 How to fill a prescription

---

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for your drug.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you**. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

### SECTION 9 Part D drug coverage in special situations

---

#### Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

#### Section 9.2 As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Provider & Pharmacy Directory* [go.wellcare.com/2026providerdirectories](https://go.wellcare.com/2026providerdirectories) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-888-846-4262 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.



## Chapter 5 Using plan coverage for Part D drugs

---

If you're a resident in an LTC facility and need a drug that isn't on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

### Section 9.3 If you also get drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

#### **Special note about creditable coverage:**

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that's expected to pay, on average, at least as much as Medicare's standard drug coverage.

**Keep any notices about creditable coverage** because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

### Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

## SECTION 10 Programs on drug safety and managing medications

---

We conduct drug use reviews to help make sure our members get safe and appropriate care.



## Chapter 5 Using plan coverage for Part D drugs

---

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we'll work with your provider to correct the problem.

### Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new



## Chapter 5 Using plan coverage for Part D drugs

---

decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

### **Section 10.2 Medication Therapy Management (MTM) program to help members manage medications**

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-888-846-4262 (TTY users call 711).

## **SECTION 11 Your *Part D Explanation of Benefits* explains which payment stage you're in**

---

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:



## Chapter 5 Using plan coverage for Part D drugs

---

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable

### Section 11.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.



## Chapter 5 Using plan coverage for Part D drugs

---

- If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services at 1-888-846-4262 (TTY users call 711). **Instead of receiving a paper *Part D Explanation of Benefits (Part D EOB)* via the mail, you now have the option of receiving an electronic version of your *Part D EOB*.** You may request this by visiting <https://www.express-scripts.com/>. If you choose to opt-in, you will receive an email when your *Part D eEOB* is ready to view, print or download. Electronic *Part D EOBs* are also referred to as paperless *Part D EOBs*. Paperless *Part D EOBs* are exact copies (images) of printed *Part D EOBs*. Be sure to keep these reports.



## **Chapter 6 What you pay for Part D drugs**

---

# **CHAPTER 6:**

## **What you pay for Part D drugs**

You pay nothing for Part D drugs covered by our plan.



## CHAPTER 7:

# Asking us to pay a bill for covered medical services or drugs

### SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

---

Our network providers bill our plan directly for your covered services and drugs – you shouldn’t get a bill for covered services or drugs. If you get a bill for medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we’ll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we’ll pay the provider directly.

**If you already paid for a Medicare service or item covered by our plan,** you can ask our plan to pay you back (paying you back is often called **reimburse** you). It is your right to be paid back by our plan whenever you’ve paid for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you’ve already paid, we’ll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we’ll pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn’t work, send the bill to us instead of paying it. We’ll look at the bill and decide whether the services should be covered. If we decide they should be covered, we’ll pay the provider directly. If we decide not to pay it, we’ll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

#### **1. When you got emergency or urgently needed medical care from a provider who’s not in our plan’s network**

- You can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.
- If you pay the entire amount yourself at the time you get the care, ask us to pay you back. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment that you think you don’t owe. Send us this bill, along with documentation of any payments you made.



**Chapter 7 Asking us to pay a bill for covered medical services or drugs**

---

- If the provider is owed anything, we'll pay the provider directly.
- If you already paid for the service, we'll pay you back.

**2. When a network provider sends you a bill you think you shouldn't pay**

Network providers should always bill our plan directly. But sometimes they make mistakes and ask you to pay for your services.

- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, send us the bill along with documentation of any payment you made. Ask us to pay you back for your covered services.

**3. If you're retroactively enrolled in our plan**

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

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

**4. When you use an out-of-network pharmacy to fill a prescription**

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

**5. When you pay the full cost for a prescription because you don't have our plan membership card with you**

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.



## Chapter 7 Asking us to pay a bill for covered medical services or drugs

---

### 6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

### 7. If you are retroactively enrolled in our plan because you were eligible for Hawaii Med-QUEST Division Program (Medicaid).

Medicaid is a joint Federal and state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicaid are automatically enrolled in our plan to get their prescription drug coverage. Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

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

- Send a copy of your receipts to us when you ask us to pay you back.
- You should ask for payment for your out-of-pocket expenses (not for any expenses paid for by other insurance).
  - The plan may not pay for drugs that are not on our drug list. All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.



**Chapter 7 Asking us to pay a bill for covered medical services or drugs**

---

**SECTION 2 How to ask us to pay you back or pay a bill you got**

---

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 365 days (for medical claims) and within three years (for drug claims)** of the date you got the service, item, or drug.

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

- You don't have to use the form, but it'll help us process the information faster. For Member Reimbursements, we do have claim forms available via the web portal. While we strongly recommend that our members use the form, to ensure all documentation is submitted, it is not necessary. They can also submit a copy of the bill without the form. Either way they should include the provider information, dates of service, Current Procedural Terminology (CPT) codes when applicable, diagnosis codes or descriptions and billed amounts along with any medical records available to them and if necessary, a brief description of why they required care. The member should also submit proof of payment at the same time they submit the claim. Valid proof of payment is bank or credit card statements or copy of canceled check.
- Download a copy of the form from our website ([go.wellcare.com/OhanaHI](https://go.wellcare.com/OhanaHI)) or call Member Services at 1-888-846-4262 (TTY users call 711) and ask for the form.

For medical services, mail your request for payment together with any bills or paid receipts to us at this address:

**Payment Request Address**

Wellcare  
Medical Reimbursement Department  
PO Box 31370  
Tampa, FL 33631-3370

For Part D Prescription Drugs, mail your request for payment together with any bills or paid receipts to us at this address:

**Part D Payment Request Address**

Wellcare Medicare Part D Claims  
Attn: Member Reimbursement Department  
P.O. Box 31577  
Tampa, FL 33631-3577



**Chapter 7 Asking us to pay a bill for covered medical services or drugs**

---

**SECTION 3 We'll consider your request for payment and say yes or no**

---

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

**Section 3.1 If we tell you we won't pay for the medical care or drug, you can make an appeal**

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.



## CHAPTER 8:

# Your rights and responsibilities

### **SECTION 1 Our plan must honor your rights and cultural sensitivities**

---

#### **Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, audio, braille, large print, or other alternate formats, etc.)**

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan can meet these accessibility requirements include but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in languages other than English including Chinese, Korean, Hmong, Tagalog, Laotian, Cambodian/Khmer, Vietnamese, Hawaiian, Japanese, Karen, Samoan, Thai, Turkish, Uzbek, Ilocano, Burmese and audio, in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-888-846-4262 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

**第 1.1 節 我們必須以適合於您，而且符合您文化敏銳度的方式提供資訊 (用英語以外的其他語言、以語音、布萊葉盲文、大字印刷或其他替代格式等)**



## Chapter 8 Your rights and responsibilities

我們的計劃必須確保所有臨床和非臨床服務均以文化適合的方式提供，並且所有投保人皆能取得，包括英語能力有限、閱讀能力有限、聽力不全，或具有不同文化和種族背景的人士。我們的計劃符合這些協助工具要求的範例包括但不限於：提供翻譯服務、口譯服務、電傳打字機或 TTY (文字電話或電傳打字機電話) 連線。

本項計劃有免費譯員服務，可回答不會講英文的會員提出的問題。如果您需要，我們也可以為用英語以外的其他語言，包括 中文、韓文、苗文、塔加洛文、柬埔寨文/高棉文、越南文、夏威夷文、日文、薩摩亞文、泰文、伊洛果文、緬甸文、土耳其文、烏茲別克文及 語音、布萊葉盲文、大字印刷或其他替代格式向您免費提供的材料。我們需要以可得取和適合您的格式向您提供有關計劃福利的資訊。若要以適合您的方式向我們取得資訊，請致電會員服務部 1-888-846-4262 (TTY 使用者請致電 711)。

我們的計劃均需讓女性投保人可以選擇直接與網絡內的女性專科醫生聯絡，以取得女性例行性和預防性健康照護服務。

如果我們計劃網絡內的專科醫生無法提供服務，我們的計劃有責任在網絡外尋找能提供您必要照護的專科醫生。在這種情況下，您只需支付網絡內分攤費用。如果您發現我們計劃的網絡中沒有您所需承保服務的專科醫生，請致電我們的計劃，瞭解如何透過網絡內分攤費用獲得此服務。

如果您無法從我們的計劃獲取可取得且適合您使用的格式之資訊，以接觸女性專科醫生或找到網絡內專科醫生，請致電會員服務部提出申訴。您也可以致電 1-800-MEDICARE (1-800-633-4227) 向 Medicare 提出投訴，或直接致電 Office for Civil Rights，電話是 1 800 368-1019 或 TTY 1-800-537-7697。

### 섹션 1.1 당사는 귀하에게 유용하고 귀하의 문화적 민감성에 맞는 방식으로 정보를 제공해야 합니다 (영어 외의 언어, 오디오, 점자, 대형 인쇄본 또는 기타 대체 형식 등).

귀하의 플랜은 모든 임상 및 비임상 서비스가 문화적으로 적합한 방식으로 제공되고, 영어 사용과 읽기 능력이 제한된 사람들, 청각 장애인 또는 다양한 문화 및 민족적 배경을 가진 모든 가입자들이 접근할 수 있도록 보장해야 합니다. 당사 플랜이 이러한 접근성 요구 사항을 충족할 수 있는 방법의 예로는 번역 및 통역 서비스 제공, 전신타자기 또는 TTY(문자 전화 또는 전신타자기 전화) 연결을 포함하되 이에 국한되지 않습니다.

당사 플랜은 비영어 사용 가입자의 질문에 답변할 수 있는 무료 통역 서비스를 제공합니다. 중국어, 몽어, 타갈로그어, 라오스어, 캄보디아어/크메르어, 베트남어, 하와이어, 일본어, 사모아어, 태국어, 일로카노어, 페르시아어, 카렌어, 터키어, 우즈베크어 를 포함한 영어 이외의 언어 를 포함한 영어 이외의 언어]로 된 자료 및 오디오, 점자, 대형 인쇄본 또는 필요한 경우 다른 대체 형식으로 무료 제공해드릴 수도 있습니다. 저희는 귀하가 이용할 수 있는 적절한 형식으로 당사 플랜 혜택에 관한 정보를 제공해야 합니다. 귀하에게 적합한 방식으로 당사로부터 정보를 확인하려면 1-888-846-4262 (TTY 사용자: 711)번으로 가입자 서비스부에 전화해 주십시오.

당사 플랜은 여성 가입자에게 여성의 일상 및 예방 건강 관리 서비스에 대한 네트워크 소속 여성 건강 전문의에 직접 접근할 수 있는 옵션을 제공해야 합니다.

전문 분야에 대한 제공자를 당사 플랜의 네트워크에서 찾을 수 없는 경우 필요한 관리를 제공할 네트워크 외부의 전문 제공업체를 찾는 것은 당사 플랜의 책임입니다. 이 경우 네트워크 소속 비용 부담만 납부하게 됩니다. 당사 플랜 네트워크에 귀하가 필요로 하는 서비스를 제공하는 전문가가 없는 경우 당사 플랜에 전화하여 이 서비스를 받을 수 있는 위치에 대한 정보를 문의하십시오.



## Chapter 8 Your rights and responsibilities

접근이 가능하고 적절한 형식으로 당사 플랜에서 정보를 얻는 데 문제가 있거나 여성 건강 전문의를 만나거나 네트워크 소속 전문의를 찾는 데 어려움이 있는 경우 가입자 서비스부에 전화하여 고충을 접수해 주십시오. Medicare에 1-800-MEDICARE(1-800-633-4227)번으로 연락하거나 Office for Civil Rights 1-800-368-1019 또는 TTY 1-800-537-7697번으로 직접 연락하여 불만사항을 제기할 수도 있습니다.

### **Nqe 1.1 Peb yuav tsum muab cov ntaub ntawv hauv ib txoj hauv kev uas haum rau koj (hauv hom lus uas tsis yog Lus Askiv, ua ntawv Su, suab lus, luam ntawv loj, los sis lwm hom ntawv, thiab lwm yam.)**

Peb txoj phiaj xwm yuav tsum xyuas kom paub tseeb tias tag nrho cov kev pab cuam, fab kev kho mob thiab tsis cuam tshuam txog fab kev kho mob tib si, tau muab hauv tus yam ntxwv uas haum raws li fab kab lij kev cai thiab nkag cuag tau rau tag nrho cov neeg tso npe nkag, suav nrog cov neeg uas paub Lus Askiv tsis tshua zoo, nyeem ntawv tau tsis tshua zoo, tsis muaj peev xwm hnov lus, los sis cov neeg uas muaj keeb kwm fab kab lis kev cai thiab haiv neeg ntau yam. Cov qauv piv txwv ntawm qhov seb peb txoj phiaj xwm puas tuaj yeem ua tau raws li cov cai kev nkag cuag no li cas ntawd yuav muaj tab sis tsis tas rau ntawm, kev muab cov kev pab cuam txhais ntawv, cov kev pab cuam txhais lus, lub tshuab ntaus ntawv, los sis kev sib txuas TTY (xov tooj xa ntawv los sis xov tooj ntaus ntawv).

Peb txoj phiaj xwm muaj cov kev pab cuam kws txhais lus pub dawb los teb cov lus nug los ntawm cov tswv cuab uas tsis hais Lus Askiv. Peb kuj tuaj yeem muab cov ntaub ntawv rau koj ua hom lus uas tsis yog Lus Askiv suav nrog Lus Suav, Lus Kaus Lim, Lus Hmoob, Lus Tagalog, Lus Nplog, Lus Kas Pus Cias/Khmer, Lus Nyab Laj, Lus Hawaii, Lus Nyij Pooj, Lus Samoan, Lus Thaib, Lus Phab Mab, Lus Karen, Lus Turkish, Lus Uzbek thiab ua suab lus, ntawv su, ntawv luam loj, los sis lwm cov hom ntawv yam tsis tau them nqi yog tias koj xav tau. Peb yuav tsum tau muab cov ntaub ntawv qhia paub rau koj hais txog peb txoj phiaj xwm cov txiaj ntsig kev pab uas yuav nkag siv tau thiab tsim nyog rau koj. Txhawm rau kom tau txais ntaub ntawv qhia paub los ntawm peb hauv ib txoj hauv kev uas siv tau rau koj, hu rau Cov Chaw Pab Cuam Rau Tswv Cuab ntawm 1-888-846-4262 (Cov neeg siv TTY hu rau 711).

Peb txoj phiaj xwm yuav tsum tau muab ib txoj kev xaiv txog kev nkag cuag ncaj qha rau cov poj niam tus kws kho mob paub tshwj xeeb txog kev noj qab haus huv nyob hauv pab pawg koom tes rau cov neeg tso npe uas yog poj niam nyob hauv pab pawg koom tes rau cov poj niam cov kev pab cuam saib xyuas kev noj qab haus huv li txhua zaum thiab rau fab kev tiv thaiv kab mob.

Yog tias koj cov kws muab kev pab cuam hauv peb txoj phiaj xwm pab pawg koom tes rau kev kho mob tshwj xeeb tsis muaj siv, nws yog peb txoj phiaj xwm lub luag hauj lwm yuav nrhiav cov kws muab kev pab cuam kho mob tshwj xeeb uas nyob sab nraud ntawm pab pawg koom tes uas yuav muab kev saib xyuas kho mob uas tsim nyog tau rau koj. Hauv qhov teeb meem no, koj tsuas yuav them kev sib faib tus nqi nyob hauv pab pawg koom tes xwb. Yog tias koj pom tias koj tus kheej nyob rau hauv qhov xwm txheej uas tsis muaj cov kws kho mob paub tshwj xeeb hauv peb txoj phiaj xwm pab pawg koom tes uas duav roos qhov kev pab cuam uas koj xav tau ntawd



## Chapter 8 Your rights and responsibilities

---

lawm, hu rau peb txoj phiaj xwm kom tau cov ntaub ntawv qhia paub txog qhov yuav mus nrhiav kom tau txais qhov kev pab cuam no ntawm kev sib faib tus nqi hauv pab pawg koom tes.

Yog tias koj muaj teeb meem dab tsi txog kev muab ntaub ntawv qhia paub los ntawm peb txoj phiaj xwm hauv ib hom ntawv uas nkag cuag tau thiab tsim nyog rau koj, mus ntsib tus kws kho mob paub tshwj xeeb txog kev noj qab haus huv ntawm poj niam los sis kev nrhiav tus kws kho mob paub tshwj xeeb hauv pab pawg koom tes, ces hu tuaj sau ntawv hais txog kev tsis txaus siab nrog Cov Chaw Pab Cuam Rau Tswv Cuab. Koj kuj tuaj yeem foob lus kev tsis txaus siab tau nrog Medicare los ntawm kev hu rau 1-800-MEDICARE (1-800-633-4227) los sis ncaj qha mus rau Office for Civil Rights 1-800-368-1019 los sis TTY 1-800-537-7697.

### **Seksyon 1.1 Dapat kaming magbigay ng impormasyon sa paraang madali para sa inyo at naaayon sa inyong mga sensitivity sa kultura (sa mga wika bukod sa Ingles, audio, braille, malaking print, o iba pang alternatibong format, atbp.)**

Kailangang tiyakin ng aming plano na ang lahat ng serbisyo, klinikal man o hindi klinikal, ay maibibigay sa isang paraang may kultural na pag-iingat at accessible sa lahat ng enrollee, kabilang na ang mga may limitadong kaalaman sa Ingles, limitadong kaalaman sa pagbabasa, problema sa pandinig, o mga taong may iba't ibang kultural at etnikong pinagmulan. Kabilang sa mga halimbawa kung paano puwedeng tugunan ng aming plano ang mga kinakailangang ito sa accessibility ang, pero hindi limitado sa, pagbibigay ng mga serbisyo ng tagasalin, serbisyo ng interpreter, teletypewriter, o koneksyon sa TTY (text telephone o teletypewriter phone).

Ang aming plano ay may libreng serbisyo sa interpretasyon na handang sumagot sa mga tanong ng mga miyembrong hindi nagsasalita ng Ingles. Puwede ka rin naming bigyan ng mga materyales sa mga wika bukod sa Ingles kasama ang Tsino, Koreano, Hmong, Tagalog, Laotian, Cambodian/Khmer, Vietnamese, Hawaiian, Hapon, Samoan, Thai, Ilocano, Burmese, Karen, Turkish, Uzbek at audio, braille, malaking print, o iba pang alternatibong format nang libre kung kailangan mo ito. Inaatasan kaming bigyan kayo ng impormasyon tungkol sa mga benepisyo ng aming plano sa isang format na accessible at naaangkop para sa inyo. Para makakuha ng impormasyon mula sa amin sa paraang gumagana para sa inyo, tumawag sa numero ng Mga Serbisyo para sa Miyembro sa 1-888-846-4262 (Dapat tumawag ang mga user ng TTY sa 711).

Kailangan ng aming plano na bigyan ang mga babaeng enrollee ng opsyon para direktang mag-access ng espesyalista sa kalusugan ng kababaihan na nasa network para sa mga regular at pang-agap na serbisyo sa pangangalagang pangkalusugan ng mga kababaihan.

Kung walang available na tagapagbigay ng serbisyong nasa network ng aming plano para sa isang specialty, responsibilidad ng aming plano na maghanap ng mga specialty na tagapagbigay ng serbisyong nasa labas ng network na magbibigay sa inyo ng kinakailangang pangangalaga. Sa ganitong sitwasyon, ang bahagian sa gastos na nasa network lang ang babayaran ninyo. Kung nasa sitwasyon kayo kung saan walang espesyalista sa network ng aming plano na sumasaklaw sa serbisyong kailangan ninyo, tawagan ang aming plano para malaman kung saan pupunta para makuha ang serbisyong ito sa bahagian sa gastos na nasa network.



## Chapter 8 Your rights and responsibilities

Kung mayroon kayong anumang problema sa pagkuha ng impormasyon mula sa aming plano sa isang format na accessible at naaangkop sa inyo, pagpapatingin sa espesyalista sa kalusugan ng kababaihan, o paghahanap ng espesyalista sa network, tumawag para maghain ng karaingan sa Mga Serbisyo para sa Miyembro. Puwede rin kayong maghain ng reklamo sa Medicare sa pamamagitan ng pagtawag sa 1-800-MEDICARE (1-800-633-4227) o nang direkta sa Office for Civil Rights sa 1-800-368-1019 o TTY 1-800-537-7697.

### ພາກທີ 1.1

**ພວກເຮົາຕ້ອງໃຫ້ຂໍ້ມູນໃນວິທີການທີ່ເໝາະສົມສໍາລັບທ່ານແລະສອດຄ່ອງກັບຄວາມອ່ອນໄຫວທາງວັດທະນະທຳຂອງທ່ານ (ໃນພາສາອື່ນນອກຈາກພາສາອັງກິດ, ສຽງ, ຕົວອັກສອນ, ພິມໃຫຍ່, ຫຼືຮູບແບບສະຫຼັບອື່ນໆ, ແລະອື່ນໆ)**

ຖືບັນເລື່ອງຈຳເປັນທີ່ແຜນປະກັນຂອງພວກເຮົາແມ່ນຕ້ອງຮັບປະກັນວ່າການບໍລິການທັງຫມົດ, ທັງທາງດ້ານຄລີນິກ ແລະບໍ່ແມ່ນທາງດ້ານຄລີນິກ, ໄດ້ໃຫ້ບໍລິການລັກສະນະທີ່ເໝາະສົມທາງວັດທະນະທຳ ແລະ ສາມາດເຂົ້າເຖິງທຸກຄົນ, ລວມທັງຜູ້ທີ່ມີຄວາມຮູ້ພາສາອັງກິດທີ່ຈຳກັດ, ທັກສະການອ່ານທີ່ຈຳກັດ, ຄວາມບໍ່ສາມາດໄດ້ຍິນ, ຫຼືຜູ້ທີ່ມີຜົນຖານວັດທະນະທຳແລະຊົນເຜົ່າທີ່ຫຼາກຫຼາຍ.

ຕົວຢ່າງຂອງວິທີການທີ່ແຜນປະກັນຂອງພວກເຮົາສາມາດຕອບສະຫນອງຄວາມຕ້ອງການການເຂົ້າເຖິງເຫຼົ່ານີ້ໄດ້ ລວມມີແຕ່ບໍ່ຈຳກັດ, ການສະຫນອງການບໍລິການແປພາສາ, ບໍລິການລ່າມແປພາສາ, ເຄື່ອງພິມດິດໂທລະເລກ, ຫຼື TTY (ໂທລະສັບຂໍ້ຄວາມຫຼື ໂທລະສັບພິມດິດໂທລະເລກ).

ແຜນປະກັນຂອງພວກເຮົາມີບໍລິການລ່າມແປພາສາຟຣີສໍາລັບສະມາຊິກທີ່ບໍ່ສະເວົ້າພາສາອັງກິດ.

ພວກເຮົາສາມາດສະໜອງຂໍ້ມູນຕ່າງໆເປັນ ເປັນພາສາອື່ນໆນອກຈາກພາສາອັງກິດ ລວມມີ ຈີນ, ເກົາຫຼີ, ມົ້ງ, ຕາກາລໍອດຟກ, ລາວ, ກຳປູເຈຍ/ຂະເມນ, ຫວຽດນາມ, ຮາວາຍ, ອິນຊີ, ຊາມິວ, ໄທ, ອິໂລກາໂນ, ມຽນມາ, ຄາເລັນ, ເຕີກກີ, ອູເບກສະຖານ ແລະ ສຽງ, ຕົວອັກສອນນູນ, ພິມໃຫຍ່, ຫຼືຮູບແບບສະຫຼັບອື່ນໆໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍໃດໆຖ້າທ່ານຕ້ອງການ.

ພວກເຮົາຈຳເປັນຕ້ອງໃຫ້ຂໍ້ມູນກ່ຽວກັບຜົນປະໂຫຍດຂອງແຜນປະກັນຂອງພວກເຮົາໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແລະເໝາະສົມສໍາລັບທ່ານ. ເພື່ອຮັບຂໍ້ມູນຈາກພວກເຮົາໃນຮູບແບບທີ່ສະດວກສໍາລັບທ່ານ, ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ 1-888-846-4262 (ຜູ້ໃຊ້ TTY ໂທ 711).

ແຜນປະກັນຂອງພວກເຮົາຈຳເປັນຕ້ອງໃຫ້ທາງເລືອກແກ່ຜູ້ລົງທະບຽນເພດຍິງ

ໃນການເຂົ້າເຖິງຜູ້ຊ່ວຍດ້ານສຸຂະພາບສໍາລັບຜູ້ຍິງພາຍໃນເຄືອຂ່າຍໂດຍກົງເພື່ອສະໜອງການບໍລິການເບິ່ງແຍງປະຈຳວັນ ແລະ ການປ້ອງກັນ.

ຖ້າບໍ່ມີຜູ້ໃຫ້ບໍລິການຢູ່ໃນເຄືອຂ່າຍຂອງແຜນປະກັນຂອງພວກເຮົາສໍາລັບບໍລິການສະເພາະທາງ, ມັນເປັນຄວາມຮັບຜິດຊອບຂອງແຜນປະກັນຂອງພວກເຮົາທີ່ຈະຊອກຫາຜູ້ໃຫ້ບໍລິການພິເສດຢູ່ນອກເຄືອຂ່າຍທີ່ຈະສະຫນອງການບໍລິການທີ່ຈຳເປັນໃຫ້ທ່ານ. ໃນກໍລະນີດັ່ງກ່າວ, ທ່ານຈະໄດ້ຈ່າຍສະເພາະຄ່າແບ່ງບັນຄ່າໃຊ້ຈ່າຍໃນເຄືອຂ່າຍເທົ່ານັ້ນ.

ຖ້າທ່ານພົບວ່າຕົວທ່ານເອງຢູ່ໃນສະຖານະການ

ທີ່ບໍ່ມີຜູ້ຊ່ວຍດ້ານໃນເຄືອຂ່າຍຂອງແຜນປະກັນຂອງພວກເຮົາທີ່ກວມເອົາການບໍລິການທີ່ທ່ານຕ້ອງການ, ໃຫ້ໂທຫາແຜນປະກັນຂອງພວກເຮົາເພື່ອຂໍຂໍ້ມູນກ່ຽວກັບບ່ອນທີ່ຈະໄປຮັບການບໍລິການນີ້

ໃນການແບ່ງບັນຄ່າໃຊ້ຈ່າຍໃນເຄືອຂ່າຍ.

ຖ້າຫາກວ່າທ່ານມີບັນຫາໃດໜຶ່ງໃນການຮັບຂໍ້ມູນຈາກແຜນປະກັນຂອງພວກເຮົາໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ ແລະເໝາະສົມສໍາລັບທ່ານ, ເຂົ້າພົບຜູ້ຊ່ວຍດ້ານສຸຂະພາບແມ່ຍິງ ຫຼື ຄົນຫາຜູ້ຊ່ວຍດ້ານໃນເຄືອຂ່າຍ, ໂທເພື່ອອີ່ນຄໍາຮ້ອງທຸກກັບຝ່າຍບໍລິການສະມາຊິກ. ນອກນັ້ນທ່ານຍັງສາມາດອີ່ນຄໍາຮ້ອງທຸກກັບ Medicare



## Chapter 8 Your rights and responsibilities

ໂດຍການໂທຫາ 1-800-MEDICARE (1-800-633-4227) ឬໂດຍກົງກັບ Office for Civil Rights ທີ່ 1-800-368-1019 ຫຼື TTY 1-800-537-7697.

### ផ្នែកទី 1.1 ເພິ່ນត្រូវតែផ្តល់ព័ត៌មានតាមរបៀបដែលអ្នកអាចយល់បាន និងតាមលក្ខណៈសមស្របຂាងវប្បធម៌របស់អ្នក (ជាភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស ជាសំឡេង អក្សរស្នាបសម្រាប់ជនពិការភ្នែក ពុម្ពអក្សរធំ ឬទម្រង់ជំនួសផ្សេងទៀតជាដើម)

គម្រោងរបស់យើងត្រូវបានອາមຈາរឱ្យធានាថា សេវាកម្មទាំងអស់ ទាំងផ្នែកគ្លីនិក និងមិនមែនផ្នែកគ្លីនិក  
ត្រូវបានផ្តល់ជូនក្នុងលក្ខណៈដែលមានសមត្ថភាពខាងផ្នែកវប្បធម៌  
ហើយអាចផ្តល់លទ្ធភាពប្រើប្រាស់ដល់អ្នកចុះឈ្មោះទាំងអស់ រួមទាំងអ្នកដែលមានជំនាញភាសាអង់គ្លេសមានកម្រិត  
ជំនាញមានកម្រិត អសមត្ថភាពក្នុងការស្តាប់ ឬអ្នកដែលមានប្រវត្តិវប្បធម៌ និងជាតិសាសន៍ចម្រុះ។  
ឧទាហរណ៍អំពីរបៀបដែលគម្រោងរបស់យើងអាចបំពេញតាមតម្រូវការនៃលទ្ធភាពចូលប្រើប្រាស់ទាំងនេះរួមមាន  
ជាអាទិ៍ដូចជា ការផ្តល់ជូនសេវាអ្នកបកប្រែឯកសារ សេវាអ្នកបកប្រែផ្ទាល់មាត់ អ្នកសរសេរនូវលេខ ឬការតភ្ជាប់ TTY  
(ទូរសព្ទជាអក្សរ ឬទូរសព្ទជាទូរលេខ)។

គម្រោងរបស់យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ  
ដែលអាចឆ្លើយនឹងសំណួរពីសមាជិកដែលមិននិយាយភាសាអង់គ្លេស។ យើងក៏អាចផ្តល់ឱ្យអ្នកនូវឯកសារជា  
ភាសាផ្សេងក្រៅពីភាសាអង់គ្លេសរួមមាន ចិន, កូរ៉េ, ម៉ុង, តាកាឡុក, ឡាវ, កម្ពុជា/ខ្មែរ, វៀតណាម, ហាវ៉ៃ, ជប៉ុន, សាម៉ូ, ថៃ,  
អាមេនី, កាប៊ីន, ឡាតី, អ៊ីសបេក និង អូឌីយ៉ូ អក្សរស្នាបសម្រាប់ជនពិការភ្នែក ជាពុម្ពអក្សរធំ  
ឬជាទ្រង់ទ្រាយជំនួសផ្សេងទៀតដោយមិនគិតថ្លៃប្រសិនបើអ្នកត្រូវការវា។  
យើងត្រូវបានតម្រូវឱ្យផ្តល់ជូនអ្នកនូវព័ត៌មានអំពីអត្ថប្រយោជន៍នៃគម្រោងរបស់យើងក្នុងទម្រង់ដែលអាចចូលប្រើបាន  
និងសមស្របសម្រាប់អ្នក។ ដើម្បីទទួលបានព័ត៌មានពីយើងតាមរបៀបមួយដែលអ្នកអាចយល់បាន  
សូមទូរសព្ទទៅផ្នែកសេវាបម្រើសមាជិកតាមលេខ 1-888-846-4262 (អ្នកប្រើ TTY សូមទូរសព្ទទៅលេខ 711)។

គម្រោងរបស់យើងត្រូវបានតម្រូវឱ្យផ្តល់ឱ្យអ្នកចុះឈ្មោះជាស្ត្រីនូវជម្រើសនៃការចូលទៅជួបអ្នកឯកទេសសុខភាពស្ត្រីដោយផ្ទាល់  
នៅក្នុងបណ្តាញសម្រាប់សេវាសុខភាពជាប្រចាំ និងការថែទាំបង្ការជំងឺរបស់ស្ត្រី។

ប្រសិនបើអ្នកផ្តល់សេវាក្នុងបណ្តាញសម្រាប់ឯកទេសមួយមិនមានទេ  
វាជាទំនួលខុសត្រូវរបស់គម្រោងរបស់យើងក្នុងការស្វែងរកអ្នកផ្តល់សេវាឯកទេសនៅក្រៅបណ្តាញ  
ដែលនឹងផ្តល់ឱ្យអ្នកនូវការថែទាំចាំបាច់នោះ។ ក្នុងករណីនេះ  
អ្នកនឹងចំណាយតែលើការចែករំលែកថ្លៃចំណាយក្នុងបណ្តាញប៉ុណ្ណោះ។  
ប្រសិនបើអ្នកស្ថិតនៅក្នុងស្ថានភាពដែលមិនមានអ្នកឯកទេសនៅក្នុងបណ្តាញគម្រោងរបស់យើង  
ដែលធានារ៉ាប់រងលើសេវាកម្មដែលអ្នកត្រូវការ សូមទូរសព្ទទៅគម្រោងរបស់យើងសម្រាប់ព័ត៌មានអំពីកន្លែងដែល  
ត្រូវទៅទទួលបានសេវាកម្មនេះដោយមានការចែករំលែកថ្លៃចំណាយក្នុងបណ្តាញ។  
ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើងក្នុងទម្រង់ដែលអាចចូលប្រើប្រាស់បាន  
និងសមស្របសម្រាប់អ្នក ក្នុងការជួបអ្នកឯកទេសខាងសុខភាពស្ត្រី ឬការស្វែងរកអ្នកឯកទេសក្នុងបណ្តាញ  
សូមទូរសព្ទទៅដាក់បណ្តឹងសាទុក្ខជាមួយផ្នែកសេវាបម្រើសមាជិក។ អ្នកក៏អាចដាក់ពាក្យបណ្តឹងតវ៉ាជាមួយ Medicare  
ដោយទូរសព្ទទៅលេខ 1-800-MEDICARE (1-800-633-4227) ឬដោយផ្ទាល់ជាមួយការិយាល័យ Office for Civil  
Rights 1-800-368-1019 ឬ TTY 1-800-537-7697។

**Phần 1.1** Chúng tôi phải cung cấp thông tin cho quý vị bằng những hình thức mà quý vị sử dụng được và phù hợp với những khác biệt về văn hóa của quý vị (bằng những



## Chapter 8 Your rights and responsibilities

### **ngôn ngữ khác ngoài tiếng Anh, âm thanh, chữ nổi, bản in khổ chữ lớn hoặc những định dạng thay thế khác, v.v.)**

Chương trình của chúng tôi được yêu cầu đảm bảo tất cả các dịch vụ, cả lâm sàng và phi lâm sàng, được cung cấp một cách có hiểu biết về văn hóa và dễ tiếp cận đối với tất cả những người đăng ký, bao gồm cả những người có trình độ tiếng Anh hạn chế, kỹ năng đọc hạn chế, khiếm thính hoặc những người có nguồn gốc văn hóa và dân tộc đa dạng. Ví dụ về cách chương trình của chúng tôi có thể đáp ứng yêu cầu về khả năng dễ sử dụng này bao gồm, nhưng không giới hạn chỉ là cung cấp dịch vụ biên dịch, dịch vụ phiên dịch, máy đánh chữ điện báo hoặc kết nối TTY (điện thoại văn bản).

Chương trình của chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp thắc mắc của các thành viên không sử dụng tiếng Anh. Chúng tôi có thể cung cấp tài liệu bằng ngôn ngữ khác ngoài tiếng Anh, bao gồm tiếng Trung, tiếng Hàn, tiếng Hmong, tiếng Tagalog, tiếng Lào, tiếng Campuchia/Khmer, tiếng Việt, tiếng Hawaii, tiếng Nhật, tiếng Samoa, tiếng Thái, tiếng Ilocano, tiếng Miến Điện, tiếng Karen, tiếng Thổ Nhĩ Kỳ, tiếng Uzbek và âm thanh, chữ nổi, bản in khổ chữ lớn hoặc những định dạng thay thế khác miễn phí nếu quý vị cần. Chúng tôi phải cung cấp thông tin về các phúc lợi của chương trình theo định dạng dễ truy cập và thích hợp cho quý vị. Để lấy thông tin từ chúng tôi theo cách phù hợp với quý vị, hãy gọi Bộ Phận Dịch Vụ Thành Viên theo số 1-888-846-4262 (người dùng TTY gọi số 711).

Chương trình của chúng tôi phải cung cấp cho người ghi danh là phụ nữ tùy chọn tiếp cận trực tiếp bác sĩ chuyên khoa sức khỏe phụ nữ trong mạng lưới đối với dịch vụ chăm sóc sức khỏe phòng ngừa và định kỳ của phụ nữ.

Nếu không có bác sĩ chuyên khoa trong mạng lưới của chương trình, chương trình của chúng tôi phải có trách nhiệm tìm bác sĩ chuyên khoa ngoài mạng lưới để cung cấp dịch vụ chăm sóc cần thiết cho quý vị. Trong trường hợp này, quý vị sẽ chỉ thanh toán phần chia sẻ chi phí dịch vụ trong mạng lưới. Nếu quý vị cho rằng mình đang trong tình huống là không có bác sĩ chuyên khoa trong mạng lưới chương trình của chúng tôi bao trả cho dịch vụ mà quý vị cần, hãy gọi chương trình để biết thông tin về nơi nhận dịch vụ này mà quý vị chỉ thanh toán phần chia sẻ chi phí trong mạng lưới.

Nếu quý vị gặp khó khăn trong việc nhận thông tin từ chương trình của chúng tôi theo định dạng dễ sử dụng và phù hợp cho quý vị, thăm khám với bác sĩ chuyên khoa sức khỏe phụ nữ hoặc tìm bác sĩ chuyên khoa trong mạng lưới, vui lòng gọi để nộp đơn khiếu nại tới Bộ Phận Dịch Vụ Thành Viên. Quý vị cũng có thể nộp đơn khiếu nại với Medicare bằng cách gọi theo số 1-800-MEDICARE (1-800-633-4227) hoặc gọi trực tiếp đến Office for Civil Rights theo số 1-800-368-1019 hoặc TTY 1-800-537-7697.

### **Māhele 1.1 Pono mākou e hā'awi i ka 'ike ma ke 'ano e hana ai no 'oe a kūlike me kāu mau mana'o mo'omeheu (ma nā 'ōlelo 'ē a'e ma mua o ka Pelekania, ke kani, ka braille, ka pa'i nui, a i 'ole nā format 'ē a'e, a pēlā aku.)**

O kā mākou ho'olālā e hō'oi'a'i'o 'ia nā lawelawe a pau, he lapa'au a 'a'ole lapa'au paha, e hā'awi 'ia ma ke 'ano he ho'omaika'i mo'omeheu a loa'a i nā mea kau inoa a pau, me nā mea e pili ana i ka 'ole o ka 'ike Pelekania, ka hiki 'ole i ka heluhelu 'ana, hiki 'ole i ka lohe, a i 'ole nā mea i loa'a nā mo'omeheu a me nā kumu ha'awina. O nā la'ana o ke 'ano e hiki ai i kā mākou ho'olālā ke



## Chapter 8 Your rights and responsibilities

ho'okō i kēia mau koi hiki ke komo akā 'a'ole i kaupalena 'ia, ka ho'olako 'ana i nā lawelawe unuhi, nā lawelawe unuhi 'ōlelo, teletypewriters, a i 'ole ka pilina TTY (kelepona a kelepona a i 'ole kelepona kākau kelepona).

Loa'a nā lawelawe unuhi manuahi kā mākou ho'olālā e pane i nā nīnau mai nā lālā 'a'ole 'ōlelo Pelekania. Hiki iā mākou ke hā'awi iā 'oe i nā mea i loko nā 'ōlelo 'ē a'e ma waho o ka 'ōlelo Pelekania komo Pākē, Kōlea, Monā, Laokia, Cambodian/Khmer, Vietnamese, 'Ōlelo Hawai'i, Kepanī, Sāmoa, Kailani, 'Ilocano, Pulumī, Karen, Tureke, 'Uzbek a leo, braille, pa'i nui, a i 'ole nā 'ano 'ē a'e me ka uku 'ole inā pono 'oe. Pono mākou e hā'awi iā 'oe i ka 'ike e pili ana i nā pomaikai o mākou ho'olālā i kahi 'ano e kūpono a kūpono ho'i no 'oe. No ka loa'a 'ana o ka 'ike mai iā mākou ma ke 'ano kūpono iā 'oe, e kelepona iā Nā lawelawe Lālā ma 1-888-846-4262 (Kāhea nā mea ho'ohana TTY 711).

Pono ka ho'olālā e hā'awi i nā wāhine i kau inoa i ke koho pololei i ka mea 'ike ola wahine i loko o ka pūnaeweale no nā lawelawe mālama ola wahine ma'amau a me nā lawelawe mālama olakino pale.

Inā 'a'ole i loa'a nā mea ho'olako i ka pūnaeweale o kā mākou ho'olālā no kahi kūikawā, 'o kā mākou kuleana ke kuleana e 'imi i nā mea ho'olako kūikawā ma waho o ka pūnaeweale nāna e hā'awi iā 'oe i ka mālama pono. Ma kēia hihia, e uku wale 'oe i ka ka'ana like koina o ka pūnaeweale. Inā 'ike 'oe iā 'oe iho i kahi kūlana 'a'ohe mea loea i kā mākou pūnaeweale ho'olālā e uhi ana i kahi lawelawe āu e pono ai, e kelepona i kā mākou ho'olālā no ka 'ike ma kahi e hele ai e ki'i i kēia lawelawe ma ka ka'ana like 'ana i nā kumukū'ai pūnaeweale.

Inā pilikia 'oe i ka loa'a 'ana o ka 'ike mai kā mākou ho'olālā ma kahi 'ano i hiki ke loa'a a kūpono iā 'oe, ke 'ike 'ana i kahi loea olakino wahine a i 'ole ka 'imi 'ana i kahi loea pūnaeweale, kelepona e waiho i ka hoopii me ka Nā lawelawe Lālā. Hiki iā 'oe ke ho'opii pololei me Medicare ma ka kelepona 1-800-MEDICARE (1-800-633-4227) a i 'ole pololei me ka Office for Civil Rights 1-800-368-1019 i 'ole TTY 1-800-537-7697.

### セクション 1.1 弊社は、お客様の文化的感受性（英語以外の言語、音声、点字、文字サイズの大きい印刷、その他の代替形式など）に一致する情報を提供する必要があります。

プランでは、臨床と非臨床の両方のサービスが、すべて文化的能力のある方法で提供され、英語の能力や読解力に制限のある方や聴覚障がいのある方、あるいはさまざまな文化および民族的背景を持つ方など、すべての登録者がアクセスできるようにする必要があります。プランがこのようなアクセシビリティ要件を満たす例には、翻訳サービス、通訳サービス、テレタイプライター、または TTY（テキスト電話またはテレタイプライター電話）接続などがありますが、これらに限定されません。

弊社プランでは、英語を話さない方からの質問に回答するための無料の通訳サービスが用意されています。また、資料を英語以外の次の言語: 中国語, 韓国語, モン語, タガログ語, ラオ語, カンボジア語/クメール語, ベトナム語, ハワイ語, 日本語, サモア語, タイ語, イロカノ語, ビルマ語, カレン語, トルコ語, ウズベク語 の音声、点字、文字サイズの大きい印刷、その他の代替形式で必要に応じて無償で提供します。弊社は、お客様がアクセスできる、適切な形式でプランの利点に



## Chapter 8 Your rights and responsibilities

関する情報を提供する必要があります。お客様に適した方法で弊社から情報を入手するには、会員サービス（1-888-846-4262）にお電話ください（TTY をご利用の場合は 711）。

弊社のプランでは、女性の皆様に日常のおよび予防的な医療サービスを提供するために、ネットワーク内の女性医療専門家に直接連絡を取れる選択肢を提供する必要があります。

プランの専門分野ネットワークに属する医療従事者が利用できない場合、プランの責任において、必要なケアを提供する医療従事者をネットワーク外で見つける必要があります。この場合、皆様はネットワーク内の費用共同負担分のみを支払うことになります。必要なサービスに対応する専門家がプランのネットワークにいない場合は、このサービスをネットワーク内の費用共同負担で受けるための方法についてプランまでお問い合わせください。

弊社のプランから、アクセス可能かつ適切な形式で情報を入手できない場合や、女性医療専門家と面談できない場合、またはネットワークの専門家を見つけることができない場合は、会員サービスまでご意見をお寄せください。また、1-800-MEDICARE（1-800-633-4227）にお電話いただくか、あるいは Office for Civil Rights 1-800-368-1019 または TTY 1-800-537-7697 に直接お電話いただき、Medicare にご意見をお寄せいただくこともできます。

**တၢ်နီၤဖး 1.1 ပကဘၣ်ဟ့ၣ်ထီၣ် တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢကျိၤကျဲလၢ အကဲထီၣ်တၢ်မၤစၢၤလၢန့ၢ်ဒီး အယူလိာ်ဖိးလိာ်သးဒီး နတၢ်ဆဲးတၢ်လၢ လၢကဘၣ်အိၣ်ဒီးတၢ်ပလီၤပဒိသး (လၢကျိၣ်တၢ်ကတိၤလၢ တမ့ၢ်ဘၣ် အဲကလံးကျိၣ်, ဒီးလၢတၢ်ဖိၣ်န့ၢ်တၢ်ကလုာ်, ပှၤမၢ်တထီၣ်တၢ်အလံာ်, လံာ်မၢ်ဖျါၣ်ဖးဒိၣ်, မ့တမ့ၢ် တၢ်အက့ၢ်အဂီၢ်အဂၤတဖၣ်, ဒီးဒံန့ၣ်အသိးတဖၣ်န့ၣ်လီၤ.)**

တၢ်ကူစါယါဘျါ ခံမံၤလိာ်, န့ၣ်ဘၣ်တၢ်ဟ့ၣ်ထီၣ်အီၤလၢ လုၢ်လံာ်လၢအလၢပုၤဒီးတၢ်ဆဲးတၢ်လၢအကီၢ်အစီအပူၤဒီး ပှၤဆဲးလီၤမံၤခဲလၢာ် ဒီးန့ၢ်အီၤကသ့, ပၣ်ဃုာ်ဒီး ပှၤတဖၣ်လၢ စံးကတိၤအဲကလံးကျိၣ်တသ့ဂ့ၤဂ့ၤ, ဖးလံာ်တသ့ဂ့ၤဂ့ၤ, တၢ်န့ၢ်ဟူတၢ်ဂီၢ်ဘါစၢ်, မ့တမ့ၢ် ပှၤတဖၣ်လၢအိၣ်ဒီး တၢ်ဆဲးတၢ်လၢလၢ အလီၤဆီလိာ်သးဒီး ကလုာ်ဒုၣ်တၢ်စီၤစီၤဂီၢ်ထံး တလီၤကံလိာ်သးတဖၣ်အဂီၢ်န့ၣ်လီၤ. ပတၢ်တီၢ်ကျဲၤအံၤ ထီၣ်ဘးဝဲဒၣ် တၢ်လိာ်ဘၣ်တဖၣ်လၢ တၢ်ဒီးန့ၢ်အီၤသ့ဒီးညီ ကသ့ဝဲဒၣ်လဲၣ် အတၢ်အဒိအတၢ်အပူၤ ပၣ်ဃုာ်ဒီး တၢ်ဟ့ၣ်ထီၣ် ပှၤကွဲးကျိၣ်ထံတၢ် အတၢ်တိစၢၤမၤစၢၤတဖၣ်, ပှၤတဲကျိၣ်ထံတၢ် အတၢ်တိစၢၤမၤစၢၤတဖၣ်, တၢ်ကွဲးဆှၢလံာ်လၢလီၤတဲစီၤခိၣ်, မ့တမ့ၢ် TTY (တၢ်ကွဲးဆှၢတၢ်ကစီၣ်လၢလီၤတဲစီၤ မ့တမ့ၢ် တၢ်ကွဲးဆှၢလံာ်လၢလီၤတဲစီၤခိၣ်) တၢ်ဘျးစဲတဖၣ် သန့က့ တမ့ၢ်ဒၣ်ထဲ

ပတၢ်တီၢ်ကျဲၤန့ၣ် အိၣ်ဒီးပှၤတဲကျိၣ်တၢ်ဒီးန့ၢ်အီၤသ့လၢဘျးလဲကလီၤ ဒ်သိးကစံးဆၢတၢ်သံကွၢ်တဖၣ်လၢ ပှၤကရူၢ်ဖိတဖၣ်လၢ စံးကတိၤအဲကလံးကျိၣ်တသ့တဖၣ်အဂီၢ်န့ၣ်လီၤ. ပဟ့ၣ်န့ၢ် လံာ်လိာ်တၢ်ကွဲးနီၣ်ကွဲးယါတဖၣ်သ့ ခိဖျိ



## Chapter 8 Your rights and responsibilities

ကျိတ်တံကတိတဖန်လၢ တမ့ၢ်ဘၣ်အဲကလံးကျိတ် ပၣ်ဃုာ်ဒီး တရူးကျိတ် ခိၣ်ရံယါကျိတ် ထဲးကလီးကျိတ် လၢအိၣ်ကျိတ် ဘွဲကၢ်လံၣ်ကျိတ် ခၢ်ဘီဒိယါ/ခမၢ်ကျိတ် ဘၣ်ယဲးန့ၣ်ကျိတ် ဟၣ်ဝၣ်ယံၣ်ကျိတ် ယပၣ်ကျိတ် ဆမိအၢ်ကျိတ် ယိၣ်ကျိတ် အိၣ်လိၣ်ခါနီၣ်ကျိတ် ပယီၣ်ကျိတ် ကညီကျိတ် တူၣ်ရကၢ်ကျိတ် အူစဘဲးကျိတ် ဒီးတၢ်ဖိၣ်န့ၣ်တၢ်ကလုာ်, ပုၤမၢ်တထံၣ်တၢ်အလံာ်, လံာ်မၢ်ဖျါၣ်ဖးဒိၣ်, မ့တမ့ၢ် တၢ်အကွၢ်အဂီၢ်အဂၤတဖန် လၢတလၢ်ဘၣ်န့ၣ်စ့ ဖဲန့ၣ်လိၣ်ဘၣ်အီၤအခါန့ၣ်လီၤ. ပဘၣ်တၢ်မၤလိာ်ပုၤလၢ ကဟ့ၣ်န့ၣ် တၢ်ဂ့ၢ်တၢ်ကျိၤဘၣ်ဃးဒီး ပတၢ်တိာ်ကျဲၤ အတၢ်န့ၢ်ဘျးတဖန်အဂ့ၢ် လၢတၢ်အကွၢ်အဂီၢ်တမံၤလၢ နဒီးန့ၢ်အီၤသ့ဒီးညီဒီး အကၢ်အဘၣ်လၢနဂီၢ်န့ၣ်လီၤ. လၢကဒီးန့ၢ် တၢ်ဂ့ၢ်တၢ်ကျိၤလၢပအိၣ် လၢကျိၤကျဲၤလၢ အကဲထီၣ်တၢ်မၤစၢၤလၢနဂီၢ်အဂီၢ်, ကိးဘၣ် တၢ်တိစၢၤမၤစၢၤ ဖဲ 1-888-846-4262(ပုၤစူးကါ TTY တဖန် ကိးဘၣ် 711)တက့ၢ်.

ပတၢ်တိာ်ကျဲၤန့ၣ် ဘၣ်တၢ်မၤလိာ်အီၤလၢ ပုၤဆဲးလီၤမံၤလၢအမ့ၢ်ဟံၣ်မုၢ်တဖန်လၢ တၢ်ဃုာ်တၢ်ဘၣ်ဃးဒီး တၢ်ဒီးန့ၢ်ဘၣ် ဟံၣ်မုၢ်ဟံၣ်မၤတဖန် အဆူၣ်ချု ပုၤသ့ဘၣ်စဲၣ်နီၤလၢ ဟ့ၣ်ဘျးစဲလၢ ဟံၣ်မုၢ်ဟံၣ်မၤတဖန် အညီၣ်ဆူၣ်ချုတၢ်ကွၢ်ထွဲ တၢ်တိစၢၤမၤစၢၤဒီး တၢ်မၤကွၢ်ဆူၣ်ချုဒီးတၢ်ဆဲးကသံၣ်ဒိသဒါတၢ်ဆါအပူၤ လီၤလိၤအဂီၢ်န့ၣ်လီၤ.

ကသံၣ်သရၣ်တဖန်လၢ လၢတၢ်သ့တၢ်ဘၣ်စဲၣ်နီၤလီၤဆီတမံၤအဂီၢ်န့ၣ် တၢ်ဒီးန့ၢ်အီၤမ့ၢ်တသ့ဘၣ်အယိ, တၢ်အံၤမ့ၢ်ပတၢ်တိာ်ကျဲၤအမူအဒါလၢ ကဃုထံၣ်သ့ၣ်ညါ ကသံၣ်သရၣ်ကူစါလီၤဆီတၢ်လၢ ဟ့ၣ်ဘျးစဲအချု လၢကဟ့ၣ်လီၤန့ၣ် တၢ်ကွၢ်ထွဲလၢအလိၣ်အဂီၢ်န့ၣ်လီၤ. တၢ်မၤအသးဒ်သိးအံၤအပူၤ, နကဘၣ်ဟ့ၣ်ဒ်ထဲ ဟ့ၣ်ဘျးစဲပူၤ တၢ်ဟ့ၣ်သဃဲၤ ဘူးလဲန့ၣ်လီၤ. နမ့ၢ်ထံၣ်သ့ၣ်ညါလီၤက့ၤနသးလၢ နဘၣ်ကွၢ်ဆါၣ်မၢ်တၢ်အိၣ်သးတမံၤ ဖဲလၢပတၢ်တိာ်ကျဲၤအဟ့ၣ်ဘျးစဲအပူၤ ကသံၣ်သရၣ်ကူစါလီၤဆီတၢ်လၢ အကျါၤဘၢဟ့ၣ် တၢ်တိစၢၤမၤစၢၤတမံၤလၢနလိၣ်ဘၣ်အီၤတမံၤတအိၣ်ဝဲဘၣ်အခါ, ကိးဘၣ် ပတၢ်တိာ်ကျဲၤ လၢတၢ်ဂ့ၢ်တၢ်ကျိၤဘၣ်ဃးဒီး နကဘၣ်လဲၤဃုဒီးန့ၢ်တၢ်တိစၢၤမၤစၢၤအံၤဖဲလဲၣ်လၢ ဟ့ၣ်ဘျးစဲပူၤ တၢ်ဟ့ၣ်သဃဲၤဘူးလဲအဂီၢ်န့ၣ်လဲၣ်တက့ၢ်.

နမ့ၢ်အိၣ်ဒီး တၢ်ကီတၢ်ခဲတမံၤမံၤလၢ တၢ်ဂ့ၢ်တၢ်ကျိၤလၢပတၢ်တိာ်ကျဲၤအအိၣ် လၢတၢ်အကွၢ်အဂီၢ်တမံၤလၢ နဒီးန့ၢ်အီၤသ့ဒီးညီ ဒီး အကၢ်အဘၣ်လၢနဂီၢ်, လၢကထံၣ်လိာ်ဒုးန့ၣ်သးဒီး ဟံၣ်မုၢ်ဟံၣ်မၤအဆူၣ်ချု ပုၤသ့ဘၣ်စဲၣ်နီၤတဂၤ မ့တမ့ၢ် ဃုထံၣ်န့ၢ် ပုၤသ့ဘၣ်စဲၣ်နီၤလီၤဆီလၢ ဟ့ၣ်ဘျးစဲအပူၤတဂၤန့ၣ်, ကိးလီတဲစိလၢ ကဆုၤထီၣ် တၢ်ဆိးထီၣ်တၢ်သးတမံၤဆူ တၢ်တိစၢၤမၤစၢၤ ပုၤကရူၢ်ဖိ အတၢ်မၤန့ၣ်တက့ၢ်. နဆုၤထီၣ် တၢ်သးတမံၤအဂ့ၢ်ဆူ Medicare ခီဖျိ နကိး 1-800-MEDICARE (1-800-633-4227) မ့တမ့ၢ် ဆူ ဝဲၤဒါးလၢ ထံဖိကီၢ်ဖိခွဲးယာ်တဖန်အဂီၢ် (Office for Civil Rights) 1-800-368-1019 မ့တမ့ၢ် TTY 1-800-537-7697 သ့စ့ၢ်ကိးန့ၣ်လီၤ.



## Chapter 8 Your rights and responsibilities

---

### **Vaega 1.1 E tatau ona matou tu'uina atu fa'amatalaga i se auala e aoga mo oe ma ia ogatasi ma ou uiga fa'ale-aganu'u (i gagana e ese mai le Igilisi, fa'alogo, mata'itusi tetele, lomiga tetele, po'o isi faatulagaga fa'apitoa, ma isi.)**

O la matou fuafuaga e mana'omia ina ia mautinoa o auaunaga uma, e le gata i falema'i ma e le o ni falema'i, o lo'o tu'uina atu i se tulaga fa'ale-aganu'u ma e mafai ona maua e tagata uma o lo'o lesitala, e aofia ai i latou e utiuti le tomiai fa'aPeretania, fa'atapula'aina le faitau tusi, fa'alogo le fa'alogo, po'o i latou e eseese aganu'u ma aganu'u. O fa'ata'ita'iga o le auala e mafai ai e la matou fuafuaga ona ausia nei mana'oga avanoa e aofia ai ae le gata i, tu'uina atu o au'aunaga faaliliu, auaunaga fa'aliliu upu, teletypewriters, po'o le TTY (telefoni po'o le telefoni tusitusi telefoni) feso'ota'iga.

E maua i le matou fuafuaga tagata ma auaunaga mo le faaliliu upu maua fua e taliina atu fesili mai tagata e iai manaoga faapitoa ma tagata e le faaogaina le Gagana Peretania. E mafai fo'i ona matou avatu ia te oe meafaitino i totonu gagana e ese mai le Igilisi e aofia ai Saina, Kolea, Hmong, Tagalog, Laos, Cambodia/Kemea, Vitenami, Havaii, Iapani, Samoa, Thai, Ilokano, Pemesi, Kalene, Tuki, Usipeka ma leo, braille, lolomi tetele, po'o isi fa'asologa e leai se totogi pe a e mana'omia. Matou te mana'omia e tu'uina atu ia te oe fa'amatalaga e uiga i fa'amanuiaga o la matou penefiti fuafuaga i se faatulagaga e mafai ona maua ma talafeagai mo oe. Ina ia maua faamatalaga mai ia i matou i se auala e aoga mo oe, valaau le Auaunaga a Sui Usufono i 1-888-846-4262 (TTY users call 711).

E mana'omia i la matou fuafuaga le tu'uina atu i tama'ita'i o lo'o lesitalaina le filifiliga o le tu'uina sa'o atu i se foma'i fa'apitoa i le soifua maloloina o tama'ita'i i totonu o le feso'ota'iga mo tama'ita'i masani ma puipuiga o le soifua maloloina.

Afai e le o avanoa tagata o lo'o tu'uina atu i totonu o la matou fuafuaga feso'ota'iga mo se tomiai fa'apitoa, o le matafaioi a la matou fuafuaga le su'eina o tagata e tu'uina atu fa'apitoa i fafo atu o le feso'ota'iga latou te tu'uina atu ia te oe le tausiga talafeagai. I le tulaga lea, e na'o le fa'asoaina o tau ile feso'ota'iga. Afai e te maua oe i se tulaga e leai ni tagata tomiai faapitoa i la matou fuafuaga o feso'ota'iga e aofia ai se au'aunaga e te mana'omia, vala'au la matou fuafuaga mo fa'amatalaga po'o fea e te alu i ai e maua ai lenei auaunaga ile fefa'asoa'i tau feso'ota'iga.

Afai e iai sau fa'afitauli i le mauaina o fa'amatalaga mai la matou fuafuaga i se faatulagaga e mafai ona maua ma talafeagai mo oe, va'ai se foma'i fa'apitoa mo le soifua maloloina o tama'ita'i po'o le su'eina o se foma'i fa'apitoa i feso'ota'iga, valaau e tuuina atu se faasea i le Auaunaga mo Sui Resitala. E mafai fo'i ona fai sau faasea ile Medicare ile vala'au ile 1-800-MEDICARE (1-800-633-4227) pe tuusa'o ile Office for Civil Rights 1-800-368-1019 po'o le TTY 1-800-537-7697.



## Chapter 8 Your rights and responsibilities

### ส่วนที่ 1.1 เราต้องให้ข้อมูลในลักษณะที่เหมาะสมกับคุณและสอดคล้องกับความอ่อนไหวทางวัฒนธรรมของคุณ (เป็นภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เป็นเสียง เป็นอักษรเบรลล์ เป็นสิ่งพิมพ์ขนาดใหญ่ หรือเป็นรูปแบบอื่นๆ เป็นต้น)

แผนของเรากำหนดให้บริการทั้งหมด ทั้งบริการทางคลินิกและที่ไม่ใช่ทางคลินิก ต้องให้บริการในลักษณะที่มีความรู้และความสามารถทางวัฒนธรรม และผู้ลงทะเบียนทั้งหมดสามารถเข้าถึงได้ รวมถึงผู้ที่มีความเชี่ยวชาญด้านภาษาอังกฤษที่จำกัด มีทักษะการอ่านที่จำกัด ขาดความสามารถในการได้ยิน หรือผู้ที่มีภูมิหลังทางวัฒนธรรมและชาติพันธุ์ที่หลากหลาย ตัวอย่างวิธีการที่แผนของเราสามารถตอบสนองความต้องการด้านการช่วยเหลือการเข้าถึงเหล่านี้จะรวมถึงแต่ไม่จำกัดเพียง การจัดหาบริการแปลภาษา บริการล่าม การพิมพ์ทางไกล หรือการเชื่อมต่อ TTY (โทรศัพท์แบบข้อความ หรือเครื่องโทรพิมพ์) แผนของเรามีบริการล่ามฟรีเพื่อตอบคำถามจากสมาชิกที่ไม่ได้ใช้ภาษาอังกฤษ นอกจากนี้ เราสามารถมอบเนื้อหาให้แก่คุณเป็น

ภาษาอื่นนอกเหนือจากอังกฤษ ได้แก่ จีน เกาหลี บัง ตากาล็อก ลาว เขมร เวียดนาม ฮาวาย ญี่ปุ่น ซามัว ไทย อีโลกาโน พม่า กะเหรี่ยง ตุรกี อุซเบก และ เสียง อักษรเบรลล์ สิ่งพิมพ์ขนาดใหญ่ หรือรูปแบบอื่นๆ โดยไม่มีค่าใช้จ่าย หากคุณต้องการ

เราจำเป็นต้องให้ข้อมูลเกี่ยวกับสิทธิประโยชน์ของแผนของเราในรูปแบบที่คุณสามารถเข้าถึงได้และเหมาะสมกับคุณ หากต้องการข้อมูลจากเราในรูปแบบที่คุณใช้งานได้ โปรดโทรติดต่อฝ่ายบริการของสมาชิกที่ custserv1-888-846-4262 (ผู้ใช้ TTY ให้โทรไปที่ 711)

แผนของเรากำหนดให้ผู้ลงทะเบียนที่เป็นผู้หญิงสามารถเลือกที่จะเข้าถึงผู้เชี่ยวชาญด้านสุขภาพของผู้หญิงในเครือข่ายได้โดยตรงสำหรับบริการดูแลสุขภาพเป็นประจำและในเชิงป้องกันของผู้หญิง

หากผู้ให้บริการเฉพาะทางในเครือข่ายของแผนของเราไม่พร้อมให้บริการ จะถือเป็นความรับผิดชอบของแผนของเราในการค้นหาผู้ให้บริการเฉพาะทางนอกเครือข่ายผู้ที่จะให้การดูแลที่จำเป็นแก่คุณ

ในกรณีนี้คุณจะจ่ายเฉพาะการแบ่งค่าใช้จ่ายในเครือข่ายเท่านั้น หากคุณพบว่าไม่มีผู้เชี่ยวชาญในเครือข่ายของแผนของเราที่ให้บริการที่คุณต้องการ ให้โทรติดต่อแผนของเราเพื่อสอบถามข้อมูลว่าจะขอรับบริการนี้ได้จากที่ใดในรายการแบ่งค่าใช้จ่ายในเครือข่าย

หากคุณพบปัญหาในการรับข้อมูลจากแผนของเราในรูปแบบที่สามารถเข้าถึงได้และเหมาะสมกับคุณ การค้นหาผู้เชี่ยวชาญด้านสุขภาพของผู้หญิง หรือการค้นหาผู้เชี่ยวชาญในเครือข่าย โปรดโทรติดต่อเพื่อยื่นคำร้องทุกข์กับฝ่ายบริการของสมาชิก นอกจากนี้คุณยังสามารถยื่นคำร้องเรียนต่อ Medicare ได้ด้วยการโทรติดต่อหมายเลข 1 800 MEDICARE (1 800 633 4227) หรือสายตรง Office for Civil Rights 1 800 368 1019 หรือ TTY 1 800 537 7697

### Bölüm 1.1 Bilgileri, sizin için uygun olan ve kültürel hassasiyetlerinizle tutarlı bir biçimde sunmaktayız (İngilizce dışındaki dillerde, sesli olarak, Braille alfabesiyle, büyük baskıyla veya diğer alternatif biçimlerde vb.)

Hem klinik hem de klinik dışı tüm hizmetlerin, kültürel açıdan yetkin bir şekilde sunulmasını ve İngilizce yeterliliği sınırlı olanlar, okuma becerileri sınırlı olanlar, işitme güçlüğü olanlar ya da kültürel ve etnik kökenleri farklı olanlar dahil olmak üzere, tüm kayıtlı kişiler intrin erişilebilir olmasının sağlanması amacıyla planımız gereklidir. Planımızın bu erişilebilirlik gerekliliklerini nasıl



## Chapter 8 Your rights and responsibilities

karşılatabileceğine ilişkin örnekler arasında, çevirmen hizmetleri, tercüman hizmetleri, teleksler veya TTY (yazı çıktı cihaz veya teleks telefonu) yer almakla birlikte, örnekler bunlarla sınırlı değildir.

Planımızda, İngilizce konuşmayan üyelerden gelen soruları yanıtlamak için ücretsiz tercüman hizmetleri vardır. İhtiyacınız varsa Çince, Korece, Hmong dili, Tagalogca, Laosça, Kamboçça/Kmerce, Vietnamca, Hawaii Dili, Japonca, Samoaca, Tayca, İlocano Dili, Birmanca, Karence, Türkçe, Özbekçe dahil olmak üzere İngilizce dışındaki dillerde ve sesli, Braille alfabesinde, büyük baskılı veya diğer alternatif biçimlerde materyalleri de ücretsiz olarak sunabiliriz. Planımızda kapsanan haklar hakkında erişilebilir ve sizin için uygun olan bir biçimde size bilgi verme yükümlülüğümüz vardır. Sizin için uygun olan şekilde bilgi almak için 1-888-846-4262 (TTY kullanıcıları için 711) numarasını kullanarak Üye Hizmetlerini arayın.

Kadınların rutin ve önleyici sağlık hizmetleri için ağ içindeki bir kadın sağlık uzmanına doğrudan erişim seçeneğinin kadın kayıtlılara sunulması planımızda zorunludur.

Planımızın uzmanlık ağındaki sağlayıcılar kullanılamıyorsa gerekli bakımı sağlayacak olan, ağ dışında uzman sağlayıcılar bulmak planımızın sorumluluğundadır. Bu durumda, yalnızca ağ içi masraf paylaşımı için ödeme yaparsınız. Planımızın ağında, ihtiyacınız olan bir hizmeti kapsayan uzmanın bulunmadığı bir durumla karşılaşırsanız bu hizmeti ağ içi masraf paylaşımında nereden edinebileceğinizi öğrenmek amacıyla planımızı arayın.

Planımızdan, erişilebilir ve size uygun olan bir biçimde bilgi almakta, kadın sağlığı uzmanına görünmekte veya ağda bir uzman bulmakta sorun yaşıyorsanız bir şikayet bildiriminde bulunmak için lütfen Üye Hizmetlerini arayın. Ayrıca, 1-800-MEDICARE (1-800-633-4227) numaralı telefonu arayarak Medicare üzerinden veya doğrudan 1-800-368-1019 ya da TTY 1 800-537-7697 numaraları ile Office for Civil Rights üzerinden bir şikayette bulunabilirsiniz.

### **1.1-bo'lim. Biz sizga ma'lumotlarni qulay qilib va sizning madaniyatingizga (Ingliz tilidan boshqa tillarda, audioda, Brayl alifbosida, katta shriftda yoki alternativ formatlarda va h.k.) muvofiq holda yetkazib beramiz**

Bizning rejamiz barcha xizmatlar – klinik va klinik bo'lmagan xizmatlar – madaniy jihatdan muvofiq ravishda va barcha ishtirokchilarga, shu jumladan, Ingliz tilisi cheklangan shaxslarga, o'qish qobiliyatida cheklov bo'lganlarga, eshita olmaydigan shaxslarga yoki boshqa madaniyat va irq vakillariga ochiq holatda taqdim etilishini kafolatlashni maqsad qiladi. Bu talablarga javob beruvchi usullar sifatida biz tarjimon xizmatlari bilan ta'minlanishni, yozma xabar operatorlarini, TTY (teleprinter) aloqasini misol qilishimiz mumkin.

Rejamiz ingliz tilida muloqot qilmaydigan a'zolar tomonidan beriladigan savollarga javob bera oladigan bepul tarjimonga ega. Shuningdek, biz sizga hech qanday to'lovsiz Inglizcha bo'lmagan ya'ni Xitoy, Koreyscha, Xmong, Tagalog, Laoscha, Kambodja tili/Xmer, Vyetnam tili, Hawayilik, Yaponcha, Samoan, Taycha, Ilokan, Birmancha, Karen, Turkcha, O'zbekcha materiallarni, audio, Brayl alifbosidagi, katta shriftidagi yoki boshqa muqobil shakldagi materiallarni taqdim etishimiz mumkin. Biz sizga rejamizning foydalari haqida siz uchun kerakli va qulay usulda ma'lumot



## Chapter 8 Your rights and responsibilities

---

berishimiz shart. Bizdan o'zingiz uchun qulay usulda ma'lumot olish uchun 1-888-846-4262 dagi A'zolarga Xizmat ko'rsatish markaziga qo'ng'iroq qiling (TTY 711 raqamiga qo'ng'iroq qiladilar).

Biz Ayollar turmushi va salomatlikni preventiv saqlash xizmatlari tarmog'ida ayol ishtirokchilarga ayollar salomatligi mutaxassisiga bevosita murojaat qilish imkonini bermoqchimiz.

Agar rejamiz tarmog'ida muayyan yo'nalishdagi tibbiy xizmatlar ta'minotchisi bo'lmasa, sizga g'amxo'rlik qiladigan muayyan tibbiy ta'minot mutaxassislarini tarmoq tashqarisida topib joylashtirish bizning majburiyatimizga kiradi. Bu vaziyatda siz faqatgina tarmoq ichidagi xarajatnigina to'lab berasiz. Agar sizga kerakli xizmatni taqdim eta oladigan mutaxassislar rejamiz tarmog'ida bo'lmasa, tarmoq ichidagi xarajat evaziga bu xizmatni ko'rsata oladigan manzil bo'yicha ma'lumot olish uchun bizning reja markazimizga qo'ng'iroq qiling.

Agar o'zingizga kerakli va qulay shaklda ma'lumot olishda biror muammoga uchrasangiz, ayollar salomatligi mutaxassisi bilan uchrashish yoki tarmoq mutaxassisini topish, shikoyat qoldirish uchun ishtirokchilarni qo'llab-quvvatlash markaziga qo'ng'iroq qiling. Shuningdek, siz Medicare'ga shikoyat qilish uchun 1-800-MEDICARE (1-800-633-4227) ga qo'ng'iroq qilishingiz yoki bevosita 1-800-368-1019 yoki TTY 1-800-537-7697 raqamlari orqali Fuqarolar huquqlari boshqarmasi (Office for Civil Rights)ga murojaat qilishingiz mumkin.

### **Seksion 1.1 Nasken nga ipaaymi ti impormasion iti wagas a maawatam ken maitunos iti kulturayo (kadagiti lengguahe a saan la nga Ingles, iti audio, iti braille, iti dadakkel nga imprenta wenno sabali pay a kasukat a pormat, ken dadduma pay)**

Kasapulan ti planomi tapno masigurado nga amin a serbisio, ti klinikal ken saan a klinikal, ket maipaay iti wagas a maiyannatup iti kultura ken maakses dagiti amin a nagpalista, agraman dagiti nabeddengan ti panagsaoda iti Ingles, nabeddengan ti kabaelanda iti panagbasa, discapacidad ti panagdengngeg, wenno dagitay addaan kadagiti agduduma a nagappuan a kultura ken etnisidad. Iraman dagiti pagarigan no kasano a masabat ti maysa a planomi dagitoy a kasapulan iti aksesibilidad ti ngem saan a nabeddengan ti, panangipaay kadagiti serbisio iti panangiyulog ti sabali a pagsasao, serbisio ti panangitarus, dagiti teletypewriter, wenno koneksion iti TTY (text a telepono wenno teletypewriter a telepono).

Ti planomi ket addaan kadagiti tattao ken kadagiti libre a serbisio ti tagaipatarus a sidadaan a sumungbat kadagiti saludsod manipud kadagiti baldado ken miembro a saan nga Ingles ti pagsasaona. Mabalinmi pay nga ited kadakayo dagiti material iti pagsasao malaksid iti Ingles a pakairamanan ti Chinese, Korean, Hmong, Tagalog, Laotian, Cambodian/Khmer, Vietnamese, Hawaiian, Japanese, Samoan, Thai, Ilocano, Burmese, Karen, Turkish, Uzbek ken audio, braille, iti dadakkel nga imprenta, wenno dadduma pay a kasukat a pormat nga awan ti magastos no kasapulam dayta. Makalikagumkami a mangipaay kenka iti impormasion a maipapan kadagiti benepisio ti planomi iti pormat a maakses ken maitutop para kenka. Tapno makaala iti impormasion manipud kadakami iti wagas nga agtrabaho para kenka, tawagan ti Serbisio dagiti Miembro iti 1-888-846-4262 (TTY users ti tawagan 711).



## Chapter 8 Your rights and responsibilities

Maikalikagum iti planomi a mangted kadagiti babbai a nagpalista iti pagpilian iti direkta nga access iti espesialista iti salun-at dagiti babbai iti uneg ti network para kadagiti serbisio ti rutina ken manglapped a panangtaripato ti salun-at kadagiti babbai.

Nu dagiti tagaipaay ti network ti planomi para ti espesialidad ket saan a sidadaan, rebbengen ti planomi nga agbirok kadagiti tagaipaay ti espesialidad iti ruar ti planomi a mangipaay kenka ti kasapulan a panangtaripato. Iti daytoy a kasasaad, bayadam laeng ti cost sharing iti uneg ti network. Nu addaka ti kasasaad nga awan dagiti espesialista iti network ti planomi a mangsakup ti serbisio a kasapulam, tawagan ti planomi para iti impormasion nu sadinno ti papanam tapno magun-od daytoy a serbisio ti cost-sharing iti uneg ti network.

No marigrigatanka a mangala ti impormasion manipud ti planomi iti pormat a maakess ken naiparbeng para kenka, pannakipagkita kadagiti espesialista ti salun-at dagiti babbai wenno panagbirok ti espesialista ti network, maidawat a tumawag tapno mangidatag ti asug iti Serbisio dagiti Miembro. Mabalinka pay a mangidatag iti reklamo iti Medicare babaen ti panangtawag iti 1-800-MEDICARE (1-800-633-4227), wenno direkta iti Office for Civil Rights iti 1-800-368-1019 wenno TTY 1-800-537-7697.

**အပိုင်း 1.1 သင့်အတွက် ကိုက်ညီအဆင်ပြေသော ယဉ်ကျေးမှုပိုင်းဆိုင်ရာ အကဲဆတ်မှုများကို အလေးဂရုပြု၍ ပုံစံ (အင်္ဂလိပ်မဟုတ်သော ဘာသာစကားများ၊ အသံ၊ မျက်မမြင် လက်စမ်းစာ၊ ပုံနှိပ်စာလုံးအကျိုးနှင့် အခြားသော အစားထိုးပုံစံများ) အား အသုံးပြုလျက် အချက်အလက်များကို ကျွန်ုပ်တို့က ပေးအပ်ရမည်ဖြစ်ပါသည်။**

ဆေးကုသမှုဆိုင်ရာနှင့် ပတ်သက်သည်ဖြစ်စေ မပတ်သက်သည်ဖြစ်စေ ဝန်ဆောင်မှုအားလုံးကို ယဉ်ကျေးမှုအရ အဆင့်အတန်းပြည့်မီသည့် နည်းလမ်းဖြင့် ပေးအပ်ခြင်းဖြစ်စေရန်နှင့် အင်္ဂလိပ်ဘာသာစကားကျွမ်းကျင်မှု နိမ့်ပါးသူများ၊ စာဖတ်စွမ်းရည် နိမ့်ပါးသူများ၊ အကဲဖြတ်အရုံချိတ်သူများနှင့် ကွဲပြားစုံလင်သော ယဉ်ကျေးမှုနှင့် လူမျိုးရေးနောက်ခံများကို ပိုင်ဆိုင်ထားသူများအပါအဝင် စာရင်းသွင်းသူအားလုံးအတွက် လွယ်လင့်တကူလက်လှမ်းမီနိုင်စေရန် ကျွန်ုပ်တို့၏အစီအစဉ်က စီမံပေးရပါမည်။ ထိုသို့သော လွယ်လင့်တကူလက်လှမ်းမီနိုင်ရေးဆိုင်ရာ လိုအပ်ချက်များကို ကျွန်ုပ်တို့ ဖြည့်ဆည်းပေးနိုင်မည့် နည်းလမ်းများမှာ ဘာသာပြန်ဝန်ဆောင်မှုများနှင့် စကားပြန်ဝန်ဆောင်မှုများ၊ ဖုန်းထဲမှပုံစံစကားကို စာသားဖြင့်ပြောင်းသော စက်များနှင့် TTY (စာသားဖြင့်ဆက်သွယ်သော တယ်လီဖုန်း သို့မဟုတ် TTY ဖုန်း) ဖြင့် ချိတ်ဆက်မှုများအား စီစဉ်ပေးခြင်း စသည်တို့ဖြစ်ပါသည်။



## Chapter 8 Your rights and responsibilities

အင်္ဂလိပ်မဟုတ်သော ဘာသာစကားကို ပြောဆိုသည့် မန်ဘာဝင်များ၏ မေးခွန်းများကို ဖြေဆိုပေးရန်အတွက်လည်း ကျွန်ုပ်တို့၏အစီအစဉ်တွင် အခမဲ့ စကားပြောဝန်ဆောင်မှုများ ရယူနိုင်ပါသည်။ စာရွက်စာတမ်းများကို

ဤသည်တို့အပါအဝင် အင်္ဂလိပ်မဟုတ်သော ဘာသာစကားများဖြင့် ပေးအပ်နိုင်ပါသည်။ တရုတ် ကိုရီးယား မှ တဂါးလော့ဂ်အို ကမ္ဘာတစ်လွှားခမာ ဟာဝိုင်ယီ ဂျပန် ဆာမိုအာ ထိုင်း အီလိုကာနို မြန်မာ ကရင် တူရကီ ဥဇဘက် နှင့် သင်လိုအပ်ပါက အသံ၊ မျက်မမြင် လက်စမ်းစာ၊ ပုံနှိပ်စာလုံးအကဲဖြင့် အခြားသော အစားထိုးပုံစံများဖြင့်လည်း အခမဲ့ပေးအပ်နိုင်ပါသည်။

ကျွန်ုပ်တို့၏အစီအစဉ်နှင့်ပတ်သက်သော အကျိုးခံစားခွင့်များကို သင့်အတွက် လွယ်လင့်တကူ လက်လှမ်းမီနိုင်ပြီးသင့်လျော်သည့် ပုံစံတစ်မျိုးဖြင့် ပေးအပ်ရန် လိုအပ်ပါသည်။ သင့်အတွက် ကိုက်ညီအဆင်ပြေသည့် နည်းလမ်းဖြင့် ကျွန်ုပ်တို့ထံမှ အချက်အလက်များရယူရန် အဖွဲ့ဝင် ဝန်ဆောင်မှုဌာန ဖုန်းနံပါတ်၊ 1-888-846-4262 (TTY အသုံးပြုသူများ ဆက်သွယ်ရန်နံပါတ် 711) သို့ ဆက်သွယ်ပါ။

ကျွန်ုပ်တို့အစီအစဉ်အနေဖြင့် အမျိုးသမီး စာရင်းသွင်းသူများကို အမျိုးသမီးကျန်းမာရေးဆိုင်ရာ ပုံမှန်နှင့် ကိုက်ညီကာကွယ်ရေး စောင့်ရှောက်ဝန်ဆောင်မှုများအတွက် ကွန်ရက်တွင်းရှိ အမျိုးသမီးကျန်းမာရေး ကျွမ်းကျင်သူများနှင့် တိုက်ရိုက်ဆက်သွယ်ခွင့် ပေးအပ်ရန်လိုအပ်ပါသည်။

အထူးပြုနယ်ပယ်တစ်ခုအတွက် ကျွန်ုပ်တို့အစီအစဉ်၏ ကွန်ရက်အတွင်း ဝန်ဆောင်မှုပေးသူမရှိပါက သင့်ကို လိုအပ်သော စောင့်ရှောက်ကုသမှု ပေးအပ်နိုင်မည့် ကွန်ရက်ပဋိပမှ အထူးပြုပြန်ဆောင်မှုပေးသူများကို ရှာဖွေပေးရန် ကျွန်ုပ်တို့အစီအစဉ်တွင် တာဝန်ရှိပါသည်။ ထိုအနေအထားတွင် ကွန်ရက်တွင်း စရိတ်မျှဝေကျခံမှုပမာဏကိုသာ သင် ပေးချရပါမည်။ ကျွန်ုပ်တို့အစီအစဉ်၏ ကွန်ရက်အတွင်း သင်လိုအပ်သော ဝန်ဆောင်မှုများကို ပေးအပ်နိုင်သည့် အထူးကုဆရာဝန် မရှိသောအခြေအနေကို ကြုံတွေ့ရပါက ကွန်ရက်တွင်း စရိတ်မျှဝေကျခံမှုပမာဏကိုသာ ပေးချလျက် ထိုဝန်ဆောင်မှုများကို မည်သည့်နေရာ၌ ရယူနိုင်ကြောင်း ကျွန်ုပ်တို့အစီအစဉ်သို့ ဆက်သွယ်မေးမြန်းပါ။

ကျွန်ုပ်တို့အစီအစဉ်ထံမှ သင့်အတွက် လွယ်လင့်တကူ လက်လှမ်းမီနိုင်ပြီးသင့်လျော်သည့် ပုံစံဖြင့် အချက်အလက်များ ရယူရာတွင်ဖြစ်စေ အမျိုးသမီးကျန်းမာရေး ကျွမ်းကျင်သူနှင့် ပြောရန် သို့မဟုတ် ကွန်ရက်တွင်းအထူးကုဆရာဝန် ရှာဖွေရန်ဖြစ်စေ အခက်အခဲတစ်စုံတစ်ရာကြုံတွေ့ရပါက အဖွဲ့ဝင် ဝန်ဆောင်မှုဌာနထံ မကျေနပ်ချက်ကို တိုင်တန်းရန်အတွက် ဖုန်းခေါ်ဆိုပါ။ 1-800-MEDICARE (1-800-633-4227) သို့ ဖုန်းခေါ်ဆိုခြင်းဖြင့် Medicare ထံ တိုင်ကြားချက်တင်သွင်းခြင်း သို့မဟုတ် Office for



## Chapter 8 Your rights and responsibilities

---

Civil Rights ဖုန်းနံပါတ် 1-800-368-1019 သို့မဟုတ် TTY 1-800-537-7697 သို့ တိုက်ရိုက်ခေါ်ဆို  
တိုင်ကြားခြင်းကိုလည်း ပုဂ္ဂိုလ်နိုင်ပါသည်။

### Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. We don't require you to get referrals to go to network providers.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

### Section 1.3 We must protect the privacy of your personal health information

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

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

#### How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you've given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you're a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to



## Chapter 8 Your rights and responsibilities

---

federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

### **You can see the information in your records and know how it's been shared with others**

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-888-846-4262 (TTY users call 711).

### **Section 1.4 We must give you information about our plan, our network of providers, and your covered services**

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-888-846-4262 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - You may ask Member Services for more information about our network providers, including their qualifications, medical school attended, residency completion, and board certification. Both Member Services and the website can give you the most up-to-date information about changes in our network providers. This information can be found on our website at [go. wellcare.com/2026providerdirectories](https://www.wellcare.com/2026providerdirectories).
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
  - **Note:** Our plan does not reward practitioners, providers, or employees who perform utilization reviews, including those of delegated entities. Utilization Management (UM) decision making is based only on appropriateness of care and service, and existence of coverage. Additionally, the plan does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.



## Chapter 8 Your rights and responsibilities

---

- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

### Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

### You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

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

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

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.



## Chapter 8 Your rights and responsibilities

---

### How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Filling out an advance directive is your choice** (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

### If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with Hawaii Executive Office on Aging.

## Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly.**

## Section 1.7 You have the right to make recommendations about our member rights and responsibilities policy

If you have any questions or concerns about the rights and responsibilities or if you have suggestions to improve our member rights policy, share your thoughts with us by contacting Member Services.



## Chapter 8 Your rights and responsibilities

---

### Section 1.8 Evaluation of new technologies

New technologies include procedures, drugs, biological products, or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, biological products, and devices. Our plan follows Medicare's National and Local Coverage Determinations when applicable.

In the absence of a Medicare coverage determination, our plan assesses new technology or new applications of existing technologies for inclusion in applicable benefits plans to ensure members have access to safe and effective care by performing a critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, diagnostic test studies with statistically significant results that demonstrate safety and effectiveness and review of evidence based guidelines developed by national organizations and recognized authorities. Our plan also considers opinions, recommendations and assessments by practicing physicians, nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology assessment organizations, reports and publications of government agencies (for example, the Food and Drug Administration (FDA), Centers for Disease Control (CDC), and National Institutes of Health (NIH)).

### Section 1.9 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights. You have a right to be treated with respect and recognition of your dignity.

If you believe you've been treated unfairly or your rights haven't been respected *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call our plan's Member Services at 1-888-846-4262 (TTY users call 711)**
- **Call your local SHIP** at 1-888-875-9229.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

### Section 1.10 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-888-846-4262 (TTY users call 711)**
- **Call your local SHIP** at 1-888-875-9229.
- **Contact Medicare**



## Chapter 8 Your rights and responsibilities

---

- Visit [www.Medicare.gov](http://www.Medicare.gov) to read the publication *Medicare Rights & Protections* (available at: [www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf](http://www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf))
- Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

### SECTION 2 Your responsibilities as a member of our plan

---

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-888-846-4262 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card and your Hawaii Med-QUEST Division Program (Medicaid) card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand. You have the responsibility to understand your health problems and help set treatment goals that you and your doctor agree upon.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must continue to pay your Medicare premiums to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**



## CHAPTER 9:

# If you have a problem or complaint (coverage decisions, appeals, complaints)

### SECTION 1 What to do if you have a problem or concern

---

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you're having:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

**Section 3** will help you identify the right process to use and what you should do.

#### Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

### SECTION 2 Where to get more information and personalized help

---

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-888-846-4262 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**State Health Insurance Assistance Program (SHIP)**

Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. SHIP contact information is available in Chapter 2, Section 3.

**Medicare**

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit [www.Medicare.gov](http://www.Medicare.gov).

**You can get help and information from Hawaii Med-QUEST Division Program (Medicaid)**

For more information and help in handling a problem, you can also contact Hawaii Med-QUEST Division Program (Medicaid). Here are two ways to get information directly from Medicaid:

- You can call Hawaii Med-QUEST Division Program (Medicaid) at 1-800-316-8005. TTY users should call 711, hours of operation are 7:45 a.m. - 4:30 p.m. HT, Monday - Friday.
- You can visit the Hawaii Med-QUEST Division Program (Medicaid) website (<https://medquest.hawaii.gov/en.html>).

**SECTION 3 Understanding Medicare and Hawaii Med-QUEST Division Program (Medicaid) complaints and appeals**

---

You have Medicare and get help from Hawaii Med-QUEST Division Program (Medicaid). Information in this chapter applies to **all** of your Medicare and Hawaii Med-QUEST Division Program (Medicaid) benefits. This is called an integrated process because it combines, or integrates, Medicare and Hawaii Med-QUEST Division Program (Medicaid) processes.

Sometimes the Medicare and Hawaii Med-QUEST Division Program (Medicaid) processes aren't combined. In those situations, use a Medicare process for a benefit covered by Medicare and a Hawaii Med-QUEST Division Program (Medicaid) process for a benefit covered by Hawaii Med-QUEST Division Program (Medicaid). These situations are explained in **Section 6.4**.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**SECTION 4 Which process to use for your problem**

---

If you have a problem or concern, read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Hawaii Med-QUEST Division Program (Medicaid)**.

**Is your problem or concern about your benefits or coverage?**

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

**Yes.**

Go to **Section 5, A guide to coverage decisions and appeals**.

**No.**

Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service, or other concerns**.

---

**Coverage decisions and appeals**

---

**SECTION 5 A guide to coverage decisions and appeals**

---

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

**Asking for coverage decisions before you get services**

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

### Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7 of this chapter.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

### Section 5.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at 1-888-846-4262** (TTY users call 711)



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-888-846-4262 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at [go.wellcare.com/OhanaHI](http://go.wellcare.com/OhanaHI).)
  - For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
  - If your doctor or other health provider asks that a service or item that you're already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

If you want a friend, relative, or other person to be your representative, call Member Services at 1-888-846-4262 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at [go.wellcare.com/OhanaHI](http://go.wellcare.com/OhanaHI).) This form gives that person permission to act on your behalf. It must be signed by you and the person you want to act on your behalf. You must give us a copy of the signed form.

We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

### Section 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines, we give the details for each of these situations:



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- **Section 6:** “Medical care: How to ask for a coverage decision or make an appeal”
- **Section 7:** “Part D drugs: How to ask for a coverage decision or make an appeal”
- **Section 8:** “How to ask us to cover a longer inpatient hospital stay if you think you’re being discharged too soon”
- **Section 9:** “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which information applies to you, call Member Services at 1-888-846-4262 (TTY users call 711). You can also get help or information from your SHIP.

---

**SECTION 6 Medical care: How to ask for a coverage decision or make an appeal**

---

**Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for your care**

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we’ll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you’re in any of the 5 following situations:

1. You aren’t getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won’t approve the medical care your doctor or other health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won’t pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You’re told that coverage for certain medical care you’ve been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

**Note:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 8 and 9. Special rules apply to these types of care.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**Section 6.2 How to ask for a coverage decision****Legal Terms:**

A coverage decision that involves your medical care is called an **organization determination**.

A **fast coverage decision** is called an **expedited determination**.

**Step 1: Decide if you need a standard coverage decision or a fast coverage decision.**

**A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs.**

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

**Step 2: Ask our plan to make a coverage decision or fast coverage decision.**

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

**Step 3: We consider your request for medical care coverage and give you our answer.**

***For standard coverage decisions we use the standard deadlines.***

**This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.**



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

***For fast coverage decisions we use an expedited timeframe.***

**A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.**

- **However**, if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no.

**Step 4: If we say no to your request for coverage for medical care, you can appeal.**

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

### Section 6.3 How to make a Level 1 appeal

#### Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration**.

**Step 1: Decide if you need a standard appeal or a fast appeal.**

**A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.**



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2.

**Step 2: Ask our plan for an appeal or a fast appeal**

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

***If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.***

- If we decided to change or stop coverage for a service or item that you currently get, we'll send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We'll continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You'll also keep getting all other services or items (that aren't the subject of your appeal) with no changes.

**Step 3: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

***Deadlines for a fast appeal***



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

### *Deadlines for a standard appeal*

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, go to **Section 11**.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- If we say no to part or all of what you asked for, we'll send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

**Section 6.4 The Level 2 appeal process****Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

- If your problem is about a service or item that's usually **covered by Medicare**, we'll automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that's usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you'll automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 161 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that's usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that's usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after getting our plan's decision letter.

**If your problem is about a service or item Medicare usually covers:**



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**Step 1: The independent review organization reviews your appeal.**

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a free copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

***If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.***

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

***If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.***

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

**Step 2: The independent review organization gives you its answer.**

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage **within 72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

we have **24 hours** from the date we get the decision from the independent review organization

- **If the independent review organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
  - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

### If your problem is about a service or item Medicaid usually covers:

#### Step 1: Ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

#### Step 2: The Fair Hearing office gives you its answer.

The Fair Hearing office will tell you its decision in writing and explain the reasons.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we get the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.)

**If the decision is no for all or part of what you asked for, you can make another appeal.**



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

Go to **Section 10** for more information on your appeal rights after Level 2.

**Section 6.5 If you're asking us to pay you back for a bill you got for medical care**

If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. When you send us a bill you already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

**Asking for reimbursement is asking for a coverage decision from us**

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, ask us to make this coverage decision. We'll check to see if the medical care you paid for is a covered service. We'll also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- **If we say no to your request:** If the medical care *isn't* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we'll not pay for the medical care and the reasons why.

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

**To make this appeal, follow the process for appeals in Section 6.3.** For appeals concerning reimbursement, note:

- We must give you our answer within 30 calendar days after we get your appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the health care provider within 60 calendar days.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal**

---

**Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug**

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

**Part D coverage decisions and appeals****Legal Term:**

An initial coverage decision about your Part D drugs is called a **coverage determination**.

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that isn't on our plan's Drug List. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**Section 7.2 Asking for an exception****Legal Terms:**

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**.

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 2 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

**Section 7.3 Important things to know about asking for exceptions****Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception.

**We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- If we say no to your request, you can ask for another review by making an appeal.

**Section 7.4 How to ask for a coverage decision, including an exception****Legal term:**

A fast coverage decision is called an **expedited coverage determination**.

**Step 1: Decide if you need a standard coverage decision or a fast coverage decision.**

**Standard coverage decisions** are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

**If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a *drug you didn't get yet*. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

**Step 2: Ask for a standard coverage decision or a fast coverage decision.**

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form, which is available on our website [go.wellcare.com/coveragedetermination](https://go.wellcare.com/coveragedetermination). Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement**, which is the medical reason for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

### Step 3: We consider your request and give you our answer.

#### *Deadlines for a fast coverage decision*

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

#### *Deadlines for a standard coverage decision about a drug you didn't get yet*

- We must give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

#### *Deadlines for a standard coverage decision about payment for a drug you have already bought*

- We must give you our answer **within 14 calendar days** after we get your request.



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

### Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

## Section 7.5 How to make a Level 1 appeal

### Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a **plan redetermination**.

A fast appeal is called an **expedited redetermination**.

### Step 1: Decide if you need a standard appeal or a fast appeal.

*A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.*

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4.

### Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at 1-888-846-4262 (TTY: 711).** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the CMS Model Redetermination Request Form, which is available on our website [go.wellcare.com/redetermination](https://go.wellcare.com/redetermination). Include your name, contact information, and information about your claim to help us process your request.



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

- **You may submit your appeal electronically through our website at [go.wellcare.com/OhanaHI](https://go.wellcare.com/OhanaHI).**
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

### Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

### *Deadlines for a fast appeal*

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

### *Deadlines for a standard appeal for a drug you didn't get yet*

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a standard appeal about payment for a drug you already bought***

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

**Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

**Section 7.6 How to make a Level 2 appeal****Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

**Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.**

- If we say no to your Level 1 appeal, the written notice we send you'll include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

**Step 2: The independent review organization reviews your appeal.**

Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

***Deadlines for fast appeal***

- If your health requires it, ask the independent review organization for a fast appeal.
- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

***Deadlines for standard appeal***

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

**Step 3: The independent review organization gives you its answer.*****For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

***For standard appeals:***

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**What if the independent review organization says no to your appeal?**

**If the independent organization says no to part or all of your appeal**, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

**Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** talks more about the process for Level 3, 4, and 5 appeals.

**SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon**

---

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights**

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-888-846-4262 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

**1. Read this notice carefully and ask questions if you don't understand it.** It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we'll cover your hospital care for a longer time.

**2. You'll be asked to sign the written notice to show that you got it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

**3. Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at 1-888-846-4262 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at [www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](http://www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**Section 8.2 How to make a Level 1 appeal to change your hospital discharge date**

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-888-846-4262 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP), for personalized help. SHIP contact information is available in Chapter 2, Section 3. SHIP contact information is available in Chapter 2, Section 3.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

**Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.**

***How can you contact this organization?***

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

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-888-846-4262 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

a sample notice online at [www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](http://www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

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

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.*****What happens if the answer is yes?***

- If the independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

***What happens if the answer is no?***

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

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

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date**

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

**Step 1: Contact the Quality Improvement Organization again and ask for another review.**

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

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

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

**Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.*****If the independent review organization says yes:***

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

***If the independent review organization says no:***

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** talks more about Levels 3, 4, and 5 of the appeals process.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

**SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

---

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying for your care*.

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

**Section 9.1 We'll tell you in advance when your coverage will be ending****Legal Term:**

**Notice of Medicare Non-Coverage.** It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- 1. You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
  - The date when we'll stop covering the care for you.
  - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
- 2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it *doesn't* mean you agree** with our plan's decision to stop care.

**Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time**

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

- **Follow the process**



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-888-846-4262 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help: Hawaii State Health Insurance Assistance Program (SHIP) at 1-888-875-9229 (TTY users call 1-866-810-4379) 8 a.m. - 5 p.m. local time, Monday - Friday. SHIP contact information is available in Chapter 2, Section 3.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

**Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.**

***How can you contact this organization?***

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

***Act quickly:***

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

**Legal Term:**

**Detailed Explanation of Non-Coverage.** Notice that gives details on reasons for ending coverage.

***What happens during this review?***

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- By the end of the day the reviewers told us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

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

***What happens if the reviewers say yes?***

- If the reviewers say yes to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

***What happens if the reviewers say no?***

- If the reviewers say no, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

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

- If reviewers say no to your Level 1 appeal - and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

**Section 9.3      How to make a Level 2 appeal to have our plan cover your care for a longer time**

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

**Step 1: Contact the Quality Improvement Organization again and ask for another review.**

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



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

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

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

**Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.*****What happens if the independent review organization says yes?***

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

***What happens if the independent review organization says no?***

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

**Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.**

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

---

**SECTION 10 Taking your appeal to Levels 3, 4 and 5**

---

**Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests**

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

**Level 3 appeal**

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal**

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

- If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

### Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## Section 10.2 Additional Hawaii Med-QUEST Division Program (Medicaid) appeals

You also have other appeal rights if your appeal is about services or items that Hawaii Med-QUEST Division Program (Medicaid) usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

## Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

### Level 3 appeal

**An Administrative Law Judge or an attorney adjudicator who works for the federal** government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

- If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal**

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

**Level 5 appeal**

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

---

**Making complaints**

---

**SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns**

---

**Section 11.1 What kinds of problems are handled by the complaint process**

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

<b>Complaint</b>	<b>Example</b>
<b>Quality of your medical care</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the quality of the care you got (including care in the hospital)?</li> </ul>
<b>Respecting your privacy</b>	<ul style="list-style-type: none"> <li>• Did someone not respect your right to privacy or share confidential information?</li> </ul>
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"> <li>• Has someone been rude or disrespectful to you?</li> <li>• Are you unhappy with our Member Services?</li> <li>• Do you feel you're being encouraged to leave our plan?</li> </ul>
<b>Waiting times</b>	<ul style="list-style-type: none"> <li>• Are you having trouble getting an appointment, or waiting too long to get it?</li> <li>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan?               <ul style="list-style-type: none"> <li>○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.</li> </ul> </li> </ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?</li> </ul>
<b>Information you get from us</b>	<ul style="list-style-type: none"> <li>• Did we fail to give you a required notice?</li> <li>• Is our written information hard to understand?</li> </ul>



Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
<b>Timeliness</b> (These types of complaints are about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you asked for a coverage decision or made an appeal, and you think we aren’t responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"><li>• You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint.</li><li>• You believe we aren’t meeting the deadlines for coverage decisions or appeals; you can make a complaint.</li><li>• You believe we aren’t meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.</li><li>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.</li></ul>

Section 11.2 How to make a complaint

Legal Terms:

- A **complaint** is also called a **grievance**.
- Making a complaint** is called **filing a grievance**.
- Using the process for complaints** is called **using the process for filing a grievance**.
- A **fast complaint** is called an **expedited grievance**.

**Step 1: Contact us promptly – either by phone or in writing.**

- **Calling Member Services at 1-888-846-4262 (TTY users call 711) is the first step.** If there’s anything else you need to do, Member Services will let you know.
- **If you don’t want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we’ll respond to your complaint in writing.
- **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the Grievance Procedure.** To make a complaint, or if you have questions about this procedure, please call Member Services. Or you may mail us a



## Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

---

written request to the address listed under *Complaints about Medical Care* or *Complaints about Part D Prescription Drugs* in Chapter 2 of this document.

- If you ask for a written response, if you file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing.
- You need to file your complaint within 60 calendar days after the event. You can submit your complaint, formally, in writing at the address listed under *Complaints about Medical Care* or *Complaints about Part D Prescription Drugs* in Chapter 2 of this document.
- We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:
  - We deny your request for a fast review of a request for medical care or Part D drugs.
  - We deny your request for a fast review of an appeal of denied services or Part D drugs.
  - We decide additional time is needed to review your request for medical care.
  - We decide additional time is needed to review your appeal of denied medical care.
- You may submit this type of complaint by phone by calling Member Services. You may also submit the complaint to us in writing at the address listed under *Complaints about Medical Care* or *Complaints about Part D Prescription Drugs* in Chapter 2 of this document. Once we receive the expedited grievance, a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.
- **Whether you call or write, you should call Member Services at 1-888-846-4262 (TTY users call 711) right away.** You can make the complaint at any time after you had the problem you want to complain about.

### **Step 2: We look into your complaint and give you our answer.**

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more



**Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**

---

calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

**Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization**

When your complaint is about *quality of care*, you also have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

**Section 11.4 You can also tell Medicare and Hawaii Med-QUEST Division Program (Medicaid) about your complaint**

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to [www.medicare.gov/MedicareComplaintForm/home.aspx](https://www.medicare.gov/MedicareComplaintForm/home.aspx). You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

For complaints pertaining to Hawaii Med-QUEST Division Program (Medicaid) covered services, please contact your State Medicaid office. Contact information can be found in Chapter 2, Section 6.



**Chapter 10 Ending membership in our plan**

---

## CHAPTER 10:

# Ending membership in our plan

### SECTION 1 Ending your membership in our plan

---

Ending your membership in Wellcare 'Ohana Dual Align (HMO-POS D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

### SECTION 2 When can you end your membership in our plan?

---

#### Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare with a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.



## Chapter 10 Ending membership in our plan

---

- Call your State Medicaid Office at 1-800-316-8005, TTY users call 711 to learn about your Medicaid plan options.
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.
- **Your membership will usually end on the first day of the month after we get your request to change your plans.** Your enrollment in your new plan will also begin on this day.

### Section 2.2 You can end your membership during the Open Enrollment Period

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without drug coverage.
  - Original Medicare *with* a separate Medicare drug plan
  - Original Medicare *without* a separate Medicare drug plan.
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

**You get Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

### Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.



## Chapter 10 Ending membership in our plan

---

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

### Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

**You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit [www.Medicare.gov](http://www.Medicare.gov).

- Usually, when you move
- If you have Hawaii Med-QUEST Division Program (Medicaid)
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

**Enrollment time periods vary** depending on your situation.

**To find out if you're eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,



Chapter 10 Ending membership in our plan

- Original Medicare *with* a separate Medicare drug plan,
- Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

**If you get Extra Help from Medicare to pay for your drug coverage drugs:** If you switch to Original Medicare and don’t enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

**Your membership will usually end** on the first day of the month after your request to change our plan.

**Note:** Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have any questions about ending your membership you can:

- **Call Member Services at 1-888-846-4262 (TTY users call 711)**
- Find the information in the *Medicare & You 2026* handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here’s what to do:
Another Medicare health plan	<ul style="list-style-type: none"><li>• Enroll in the new Medicare health plan.</li><li>• You’ll automatically be disenrolled from Wellcare 'Ohana Dual Align (HMO-POS D-SNP) when your new plan’s coverage starts.</li></ul>



To switch from our plan to: Here’s what to do:	
Original Medicare <i>with</i> a separate Medicare drug plan	<ul style="list-style-type: none"><li>• Enroll in the new Medicare drug plan.</li><li>• You’ll automatically be disenrolled from Wellcare 'Ohana Dual Align (HMO-POS D-SNP) when your new plan’s coverage starts.</li></ul>
Original Medicare <i>without</i> a separate Medicare drug plan	<ul style="list-style-type: none"><li>• <b>Send us a written request to disenroll or visit our website to disenroll online.</b> Call Member Services at 1-888-846-4262 (TTY users call 711) if you need more information on how to do this.</li><li>• You can also call <b>Medicare</b> at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048.</li><li>• You’ll be disenrolled from Wellcare 'Ohana Dual Align (HMO-POS D-SNP) when your coverage in Original Medicare starts.</li></ul>

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Hawaii Med-QUEST Division Program (Medicaid) benefits, call 1-800-316-8005, TTY 711, 7:45 a.m. - 4:30 p.m. HT, Monday - Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Hawaii Med-QUEST Division Program (Medicaid) coverage.

### SECTION 4    Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership ends, and your new Medicare and Hawaii Med-QUEST Division Program (Medicaid) coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**



**Chapter 10 Ending membership in our plan**

---

- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

**SECTION 5 Wellcare 'Ohana Dual Align (HMO-POS D-SNP) must end our plan membership in certain situations**

---

**Wellcare 'Ohana Dual Align (HMO-POS D-SNP) must end your membership in our plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you're no longer eligible for Hawaii Med-QUEST Division Program (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Hawaii Med-QUEST Division Program (Medicaid). If you no longer meet the special eligibility requirements of our plan, your membership in this plan will end after 6-months. However, during this period, the Medicare Advantage plan is not responsible for coverage of any Hawaii Med-QUEST Division Program (Medicaid) benefits that may be included under your Medicaid State Plan. You will receive a notice from us informing you of the end of your membership and your options. If you have any questions about your eligibility, please contact Member Services.
  - The plan's period of deemed continued eligibility is 6-months. The period of deemed continued eligibility begins the first of the month following the month in which you lose special needs status
- If you move out of our service area
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services at 1-888-846-4262 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)



## Chapter 10 Ending membership in our plan

---

- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Member Services at 1-888-846-4262 (TTY users call 711).

### Section 5.1 We can't ask you to leave our plan for any health-related reason

Wellcare 'Ohana Dual Align (HMO-POS D-SNP) isn't allowed to ask you to leave our plan for any health-related reason.

#### What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

### Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.



**Chapter 11 Legal notices**

---

# CHAPTER 11:

## Legal notices

### SECTION 1 Notice about governing law

---

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

### SECTION 2 Notice about nondiscrimination

---

Our health plan complies with Federal Civil Rights Laws. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at [www.HHS.gov/ocr/index.html](http://www.HHS.gov/ocr/index.html).

If you have a disability and need help with access to care, call Member Services at 1-888-846-4262 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

### SECTION 3 Notice about Medicare Secondary Payer subrogation rights

---

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *our plan*, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises



**Chapter 11 Legal notices**

---

under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

**SECTION 4 Recovery of benefits paid by our plan under your Wellcare 'Ohana Dual Align (HMO-POS D-SNP) plan**

---

**When you are injured**

If you are ever injured, become ill or develop a condition through the actions of another person, company, or yourself (a “responsible party”), our plan will provide benefits for covered services that you receive. However, if you receive money or are entitled to receive money because of your injury, illness or condition, whether through a settlement, judgment, or any other payment associated with your injury, illness or condition, our plan and/or the treating providers retain the right to recover the value of any services provided to you through this plan in accordance with applicable State law.

As used throughout this provision, the term “responsible party” means any person or entity actually or potentially responsible for your injury, illness or condition. The term responsible party includes the liability or other insurer of the responsible person or entity.

Some examples of how you could be injured, become ill or develop a condition through the actions of a responsible party include, but are not limited to:

- You are in a car accident;
- You slip and fall in a store; or
- You are exposed to a dangerous chemical at work.

Our plan’s right of recovery applies to any and all amounts you receive from the responsible party, including but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners’ insurance coverage or umbrella coverage;
- Any settlement or judgement received from a lawsuit or other legal action; or
- Any other payments from any other source received as compensation for the responsible party’s actions or omissions.

By accepting benefits under this plan, you agree that our plan has a first priority right of subrogation and reimbursement that attaches when this plan has paid benefits for Covered Services that you



## Chapter 11 Legal notices

---

received due to the actions or omissions of a responsible party, and you or your representative recovers, or is entitled to recover, any amounts from a responsible party.

By accepting benefits under this plan, you also (i) assign to our plan your right to recover medical expenses from any coverage available up to the full cost of all Covered Services provided by the plan in connection with your injury, illness or condition, and (ii) you agree to specifically direct the responsible party to directly reimburse the plan on your behalf.

By accepting benefits under this plan, you also give our plan a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement for the full cost of benefits for Covered Services paid under the plan that are associated with your injury, illness or condition due to the actions or omissions of a responsible party. This priority applies regardless of whether the amounts are specifically identified as a recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss. Our plan may recover the full cost of all benefits provided by this plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No attorney fees may be deducted from our plan's recovery, and our plan is not required to pay or contribute to paying court costs or attorneys' fees for the attorney hired to pursue the claim or lawsuit against any responsible party.

### Steps you must take

If you are injured, become ill or develop a condition because of a responsible party, you must cooperate with our plan and/or the treating provider's efforts to recover its expenses, including:

- Telling our plan or the treating provider, as applicable, the name and address of the responsible party and/or his or her lawyer, if you know it; the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved; and a description of how the injury, illness or condition was caused.
- Completing any paperwork that our plan or the treating provider may reasonably require to assist in enforcing the lien or right of recovery.
- Promptly responding to inquiries from our plan or the treating provider about the status of the case or claim and any settlement discussions.
- Notifying our plan immediately upon you or your lawyer receiving any money from the responsible party(s) or any other source.
- Paying the health care lien or plan recovery amount from any recovery, settlement or judgment, or other source of compensation, including payment of all reimbursement due to our plan for the full cost of benefits paid under the plan that are associated with your injury, illness or condition due to a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Doing nothing to prejudice our plan's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan or any attempts to deny our plan its first priority right of recovery or lien.



## Chapter 11 Legal notices

---

- Holding any money that you or your lawyer receive from the responsible party(s), or from any other source, in trust, and reimbursing our plan or the treating provider, as applicable, for the amount of the recovery due to the plan as soon as you are paid and prior to payment of any other potential lien holders or third parties claiming a right to recover.
- You are required to cooperate with us in pursuing such recoveries or over payments.

### SECTION 5 Membership card

---

A membership card issued by our plan under this *Evidence of Coverage* is for identification purposes only. Possession of a membership card does not confer any right to services or other benefits under this *Evidence of Coverage*. To be entitled to services or benefits under this *Evidence of Coverage*, the holder of the card must be eligible for coverage and be enrolled as a member under this *Evidence of Coverage*. Any person receiving services to which he or she is not then entitled under this *Evidence of Coverage* will be responsible for payment for those services. A Member must present the plan's membership card, not a Medicare card, at the time of service. Please call Member Services at 1-888-846-4262 (TTY users call: 711) if you need your membership card replaced.

Note: Any member knowingly permitting abuse or misuse of the membership card may be disenrolled for cause. Our plan is required to report a disenrollment that results from membership card abuse or misuse to the Office of the Inspector General, which may result in criminal prosecution.

### SECTION 6 Independent contractors

---

The relationship between our plan and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of our plan and neither our plan, nor any employee of our plan, is an employee or agent of a participating provider. In no case will our plan be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not our plan, maintain the physician-patient relationship with the Member. Our plan is not a provider of health care.

### SECTION 7 Health care plan fraud

---

**Health care plan fraud is defined as a deception or misrepresentation to the plan by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by, for example, filing a claim that contains a false or deceptive statement could be guilty of health care plan fraud.**

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-866-685-8664 (TTY: 711). The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.



**Chapter 11 Legal notices**

---

**SECTION 8     Circumstances beyond the plan's control**

---

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, state of emergency or other similar events not within the control of our plan, results in our plan's facilities or personnel not being available to provide or arrange for services or benefits under this *Evidence of Coverage*, the plan's obligation to provide such services or benefits shall be limited to the requirement that our plan make a good faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.



**Chapter 12 Definitions**

---

## CHAPTER 12:

# Definitions

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

**Biological Product** – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to “**Original Biological Product**” and “**Biosimilar**”).

**Biosimilar** – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to “**Interchangeable Biosimilar**”).

**Brand Name Drug** – A prescription drug that's manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

**Centers for Medicare & Medicaid Services (CMS)** – The federal agency that administers Medicare.

**Coinsurance** – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.



## Chapter 12 Definitions

---

**Complaint** -- The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or copay)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific is received; or (3) any coinsurance amount, a percentage of the total amount paid for a that a plan requires when a specific is received.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

**Covered Drugs** – The term we use to mean all the drugs covered by our plan.

**Covered Services** – The term we use to mean all the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

**Daily cost-sharing rate** – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily



## Chapter 12 Definitions

---

cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

**Deductible** – The amount you must pay for health care or prescriptions before our plan pays.

**Disenroll** or **Disenrollment** – The process of ending your membership in our plan.

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

**Dual Eligible Special Needs Plans (D-SNP)** – DSNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

**Dually Eligible Individual** – A person who is eligible for Medicare and Medicaid coverage.

**Durable Medical Equipment (DME)** – Certain medical equipment that's ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

**Emergency** – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

**Emergency Care** – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

**Extra Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.



## Chapter 12 Definitions

---

**Generic Drug** – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

**Home Health Aide** – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

**Hospice** – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

**Income Related Monthly Adjustment Amount (IRMAA)** – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

**Independent Practice Association (IPA)** – An association of physicians, including PCPs and specialists, and other health care providers, including hospitals, that is contracted with the plan to provide services to members. See Chapter 1, Section 6.

**Initial Coverage Stage** – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

**Initial Enrollment Period** – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Integrated D-SNP** – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are also known as full-benefit dually eligible individuals.

**Integrated Grievance** – A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Integrated Organization Determination** – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you



## Chapter 12 Definitions

---

have to pay for covered items or services. Organization determinations are called coverage decisions in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Interchangeable Biosimilar** – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

**List of Covered Drugs (formulary or Drug List)** – A list of prescription drugs covered by our plan.

**Low Income Subsidy (LIS)** – Go to Extra Help.

**Manufacturer Discount Program** – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

**Maximum Fair Price** – The price Medicare negotiated for a selected drug.

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for our Medicare Part A and Part B premiums and prescription drugs don't count toward the maximum out-of-pocket amount. (Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.)

**Medicaid (or Medical Assistance)** – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medical Group** – An association of physicians, including PCPs and specialists, and other health care providers, including hospitals, that contract with the plan to provide services to enrollees. See Chapter 1, Section 3.2.

**Medically Accepted Indication** – A use of a drug that's either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage Open Enrollment Period** – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel its plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The



## Chapter 12 Definitions

---

Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug coverage**.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Drug coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**Medication Therapy Management (MTM) program** – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

**Medigap (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (member of our plan, or plan member)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Network Pharmacy** – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Network Provider – Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our



## Chapter 12 Definitions

---

payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

**Open Enrollment Period** – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

**Original Biological Product** – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

**Original Medicare (Traditional Medicare or Fee-for-Service Medicare)** – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

**Out-of-Pocket Costs** – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

**Out-of-Pocket Threshold** – The maximum amount you pay out of pocket for Part D drugs.

**Part C** – Go to Medicare Advantage (MA) plan.

**Part D** – The voluntary Medicare Prescription Drug Benefit Program.

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

**Part D Late Enrollment Penalty** – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

**Point-of-Service** – The HMO with a Point-of-Service (POS) Option is an additional benefit that covers certain medically necessary services you may get from out-of-network providers who accept Medicare.



## Chapter 12 Definitions

---

When you use your POS (out-of-network) benefit you are responsible for more of the cost of care. Always talk to your Primary Care Provider (PCP) before seeking care from an out-of-network provider. Your PCP will notify us by requesting approval from the plan (prior authorization). (See Chapter 1, Section 1.1)

**Preferred Cost Sharing** – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Preventive services** – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

**Primary Care Provider (PCP)** – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** – Approval in advance to get services or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

**Prosthetics and Orthotics** – Medical devices including, but limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

**Quantity Limits** – A management tool that's designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**“Real-Time Benefit Tool”** – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

**Referral** – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

**Rehabilitation Services** – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.



## Chapter 12 Definitions

---

**Selected Drug** – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

**Service Area** – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Needs Plan** – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

**Standard Cost Sharing** – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

**Supplemental Security Income (SSI)** – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

**Urgently Needed Services** – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

**Wellcare Spendables® card** - A debit card, preloaded by the plan that may be used to help pay for items as described in the Medical Benefits Chart.



This page intentionally left blank.



## Wellcare 'Ohana Dual Align (HMO-POS D-SNP) Member Services

Method	Member Services – Contact Information
<b>Call</b>	1-888-846-4262 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m. Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. If you leave a voicemail message, please include your name, and telephone number and a team member will return your call within one (1) business day. Member Services 1-888-846-4262 (TTY users call 711) also has free language interpreter services available for non-English speakers.
<b>TTY</b>	711 Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m.
<b>Write</b>	Wellcare By 'Ohana Health Plan PO Box 31370 Tampa, FL 33631-3370
<b>Website</b>	<a href="http://go.wellcare.com/OhanaHI">go.wellcare.com/OhanaHI</a>

## Hawaii State Health Insurance Assistance Program (SHIP)

Hawaii State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
<b>Call</b>	1-888-875-9229
<b>TTY</b>	1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.
<b>Write</b>	Hawaii SHIP, Executive Office on Aging, No. 1 Capitol District 250 South Hotel Street, Suite 406 Honolulu, Hawaii 96813-2831
<b>Website</b>	<a href="http://www.hawaiiiship.org/">http://www.hawaiiiship.org/</a>

**PRA Disclosure Statement** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.