



# WellCare® Benefit Overview<sup>(1)</sup>

	WellCare Choice Plan 025	WellCare Value Plan 079	WellCare Advance Plan 167	WellCare Select Plan 126	WellCare Access Plan 125
WellCare Monthly Plan Premium	\$29	\$0	\$0	\$19.20	\$19.20
Plan Type	HMO with a POS Option	HMO with a POS Option	HMO	HMO with a POS Option	HMO
POS Option <sup>(2)</sup>	30%	30%	Not Covered	30%	Not Covered
Maximum Out-of-Pocket	\$2,500	\$3,250	Not Covered	\$1,500	Not Covered
Doctor Office Visits (Primary Care Physician/Specialist)	\$10 / \$25	\$10 / \$30	\$10 / \$30	\$5 / \$20	\$0 / \$0
Inpatient Hospitalization	\$150 / days 1 to 5	\$200 / days 1 -5	\$100 / days 1 to 5	\$75 / days 1 to 5	\$0 / days 1 to 90
Outpatient Hospital (Surgical/Non-Surgical)	\$100 / \$100	\$150 / \$150	\$75 / \$75	\$50 / \$50	\$0 / \$0
Part D Prescription Drug Coverage <sup>(1)(3)</sup> (30-day supply)	Yes	Yes	Not Covered	Yes	Yes
Deductible	\$0	\$0	Not Covered	\$0	\$0
Tier 1/Generic	\$0	\$0	Not Covered	You pay \$0 to \$5.60 for Part D prescription drugs	You pay \$0 to \$5.60 for Part D prescription drugs
Tier 2/Preferred Brand	\$45	\$35	Not Covered	After your yearly out-of-pocket reaches \$4,050, you pay \$0 for your drugs	After your yearly out-of-pocket reaches \$4,050, you pay \$0 for your drugs
Tier 3/Non-Preferred Brand	\$85	\$75	Not Covered		
Tier 4/Specialty	33%	33%	Not Covered		
Additional Information	You pay 100% for all drugs in the coverage gap	You pay 100% for all drugs in the coverage gap	Not Covered		
Routine Dental Exams	Yes	Not Covered	Yes	Yes	Yes
Routine Hearing Exams	Yes	Not Covered	Not Covered	Yes	Yes
Routine Vision Exams	Yes	Not Covered	Not Covered	Yes	Yes
Over-the-Counter Personal Care Items	\$15 / monthly allowance <sup>(4)</sup>	Not Covered	\$10 / monthly allowance <sup>(4)</sup>	\$10 / monthly allowance <sup>(4)</sup>	\$12.50 / monthly allowance <sup>(4)</sup>
Transportation	Not Covered	Not Covered	Not Covered	\$0 / 24 one-way trips a year	Not Covered
Nutritional Support	Not Covered	Not Covered	Not Covered	\$0 / 10 meals a month	\$0 / 10 meals a month
Health Club Membership	\$0 / yearly	Not Covered	\$0 / yearly	\$0 / yearly	\$0 / yearly

*(1) See Summary of Benefits and/or contact plan for details. (2) Applies only to certain services. See Summary of Benefits and/or contact plan for details. (3) This plan uses a preferred drug list. Limitations may apply. (4) Any unused portion of your allowance does not carry over to the next month.*