Wellcare Dual Access USHS (HMO D-SNP) *offered by* Silversummit Healthplan, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of Allwell Dual Medicare Harmony USHS (HMO D-SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 and 2.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly

how much your own drug costs may change.

- ☐ Check to see if your doctors and other providers will be in our network next year.
  - Are your doctors, including specialists you see regularly, in our network?
  - What about the hospitals or other providers you use?
  - Look in Section 2.3 for information about our Provider & Pharmacy Directory.
- ☐ Think about your overall health care costs.
  - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
  - How much will you spend on your premium and deductibles?
  - How do your total plan costs compare to other Medicare coverage options?
- ☐ Think about whether you are happy with our plan.

2. **COMPARE**: Learn about other plan choices

- ☐ Check coverage and costs of plans in your area.
  - Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
  - Review the list in the back of your *Medicare & You 2022* handbook.
  - Look in Section 4.2 to learn more about your choices.
- ☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2021, you will be enrolled in Wellcare Dual Access USHS (HMO D-SNP).
   - If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 4.2, page 24. to learn more about your choices.
4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**
   - If you don't join another plan by **December 7, 2021**, you will be enrolled in Wellcare Dual Access USHS (HMO D-SNP).
   - If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in:
    - Spanish
- Please contact our member services number at 1-833-717-0806 for additional information. (TTY users should call 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.
- 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.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Wellcare Dual Access USHS (HMO D-SNP)

- Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Silversummit Healthplan, Inc. When it says "plan" or "our plan," it means Wellcare Dual Access USHS (HMO D-SNP).

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Wellcare Dual Access USHS (HMO D-SNP) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.wellcare.com/allwellnv. You may also call member services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	For covered admissions, per admission: $0 copay for each covered hospital stay. $0 copay for an additional 60 lifetime reserve days.	For covered admissions, per admission: $0 copay for each covered hospital stay. $0 copay for an additional 60 lifetime reserve days.
Part D prescription drug coverage (See Section 2.6 for details.)	If you receive "Extra Help", you pay one of the following amounts: Deductible: $0 or $92 (applies to Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier))	If you receive "Extra Help", you pay one of the following amounts: Deductible: $0 or $99 (applies to Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier))

Cost	2021 (this year)	2022 (next year)
	Copayment/Coinsurance during the Initial Coverage Stage: Depending on your level of "Extra Help," you only have to pay the following cost-sharing amounts for your prescription drugs: For generic drugs (including brand drugs treated as generic): • $0 copay or • $1.30 copay or • $3.70 copay or • 15% of the total cost of the drug For all other covered drugs: • $0 copay or • $4.00 copay or • $9.20 copay or • 15% of the total cost of the drug	Copayment/Coinsurance during the Initial Coverage Stage: Depending on your level of "Extra Help," you only have to pay the following cost-sharing amounts for your prescription drugs: For generic drugs (including brand drugs treated as generic): • $0 copay or • $1.35 copay or • $3.95 copay or • 15% of the total cost of the drug For all other covered drugs: • $0 copay or • $4.00 copay or • $9.85 copay or • 15% of the total cost of the drug

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	If you do not qualify for "Extra Help" from Medicare, you will pay the following for your prescription drugs costs: Deductible: $445 (applies to Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier)) Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 - Preferred Generic Drugs: You pay a $0 copay for a one-month (30-day) supply. • Drug Tier 2 - Generic Drugs: You pay a $20 copay for a one-month (30-day) supply. • Drug Tier 3 - Preferred Brand Drugs: You pay a $47 copay for a one-month (30-day) supply. • Drug Tier 4 - Non-Preferred Drugs: You pay 50% of the total cost for a one-month (30-day) supply. • Drug Tier 5 - Specialty Tier: You pay 25% of the total cost for a one-month (30-day) supply.	If you do not qualify for "Extra Help" from Medicare, you will pay the following for your prescription drugs costs: Deductible: $480 (applies to Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier)) Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 - Preferred Generic Drugs: You pay a $0 copay for a one-month (30-day) supply. • Drug Tier 2 - Generic Drugs: You pay a $13 copay for a one-month (30-day) supply. • Drug Tier 3 - Preferred Brand Drugs: You pay a $42 copay for a one-month (30-day) supply. • Drug Tier 4 - Non-Preferred Drugs: You pay 47% of the total cost for a one-month (30-day) supply. • Drug Tier 5 - Specialty Tier: You pay 25% of the total cost for a one-month (30-day) supply.

Cost	2021 (this year)	2022 (next year)
	• Drug Tier 6 - Select Care Drugs: Not Applicable	• Drug Tier 6 - Select Care Drugs: You pay a $0 copay for a one-month (30-day) supply.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$3,450 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.	$3,450 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.

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2022, our plan name will change from Allwell Dual Medicare Harmony USHS (HMO D-SNP) to Wellcare Dual Access USHS (HMO D-SNP).

You will receive a new ID Card in the mail that will display the new plan name on or before December 31, 2021. Going forward, all other communications regarding your 2022 plan and benefits will also reflect the new name.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1— Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** 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. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,450	$3,450 Once you have paid $3,450 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3— Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.wellcare.com/allwellnv. You may also call member services for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2022 *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider

or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 2.4— Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.wellcare.com/allwellNV. You may also call member services for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2022 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

Section 2.5— Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered)*, in your *2022 Evidence of Coverage*. A copy of the *Evidence of Coverage* is located on our website at www.wellcare.com/allwellnv. You may also call member services to ask us to mail you an *Evidence of Coverage*.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Additional services that are covered for the chronically ill	**Additional nutritional shakes** You pay a $0 copay for medically-necessary nutritional shakes.	**Additional nutritional shakes** Additional nutritional shakes are not covered as part of the services for the chronically ill.
Diabetes self-management training, diabetic services and supplies - Diabetic monitoring supplies - Preferred vendors	AccuChek™ and OneTouch™ are our preferred diabetic testing supplies (glucose monitors & supplies). Other brands are not covered unless medically necessary and pre-authorized. If you receive authorization for another brand, you will pay a $0 copay	OneTouch™ products by Lifescan are our preferred diabetic testing supplies (glucose monitors & test strips). Other brands are not covered unless medically necessary and pre-authorized.
Diabetes self-management training, diabetic services and supplies - Diabetes self-management training	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.
Emergency care - Worldwide emergency coverage	Worldwide emergency care coverage is not covered.	You pay a $120 copay for each covered service. Copayment is not waived if you are admitted to a hospital.
Emergency care - Worldwide emergency coverage	Worldwide emergency care coverage is not covered.	You are covered for up to $50,000 every year for emergency and urgently needed services outside the United States.
Fitness Membership	You pay a $0 copay for the fitness benefit. Your Silver&Fit membership does not include access to a new 1:1 Healthy Aging Coaching program.	You pay a $0 copay for the fitness benefit. Your Silver&Fit membership includes access to a 1:1 Healthy Aging Coaching program.

Cost	2021 (this year)	2022 (next year)
Flex Card	The debit Flex Card is not covered.	You receive $1,000 on your Flex Card. The debit card is prepaid by the plan for covered dental, vision, or hearing services. Your flex card benefit has a limit of $250 for vision services, the remaining balance may be spent between dental and hearing services as you see fit. Please refer to your Evidence of Coverage for more information.
Home health agency care	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.
Meals - Chronic (limitations and exclusions apply)	Meals benefit - chronic is not covered.	You pay a $0 copay for chronic meals. There is a maximum of 3 meals per day for up to 28 days, for a maximum of 84 meals per month. The benefit may be received for up to 3 months.
Meals - Post-Acute (limitations and exclusions apply)	You pay a $0 copay for post-acute meals. There is a maximum of 2 meals per day for up to 14 days, for a maximum of 28 meals.	You pay a $0 copay for post-acute meals. There is a maximum of 3 meals per day for up to 14 days, for a maximum of 42 meals.
Medical nutrition therapy - Additional medical nutrition therapy	You pay a $0 copay.	Additional medical nutrition therapy is not covered.

Cost	2021 (this year)	2022 (next year)
Medical nutrition therapy - Additional medical nutrition therapy - Non-Medicare-covered diseases - Additional sessions	Unlimited visits for medical nutrition therapy for non-medicare-covered diseases.	Additional medical nutrition therapy is not covered.
Medical nutrition therapy - Additional medical nutrition therapy - Medicare-covered diseases - Additional sessions	Unlimited visits for medical nutrition therapy for medicare-covered diseases.	Additional medical nutrition therapy is not covered.
Outpatient mental health care - additional counseling services	You pay a $0 copay for each additional counseling visit with a Medicare-qualified mental health provider in an office setting or with a Teladoc™ provider. Unlimited visits for 60 minute individual or group sessions every year.	You pay a $0 copay for each additional counseling visit with a Teladoc™ provider. Unlimited visits for 60 minute individual or group sessions every year.
Outpatient mental health care - Non-psychiatric services - Group sessions	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.
Outpatient mental health care - Psychiatric services - Group sessions	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.
Outpatient rehabilitation services - Occupational therapy	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.
Outpatient rehabilitation services - Physical therapy and speech-language pathology	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.

Cost	2021 (this year)	2022 (next year)
Outpatient substance abuse services - Individual sessions	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.
Over-the-counter benefit	You pay a $0 copay. You receive a benefit of $185 every quarter to spend on eligible over-the-counter (OTC) products via mail order. This benefit does not carry over to the next period.	You pay a $0 copay. You receive a benefit of $195 every quarter to spend on eligible over-the-counter (OTC) products via mail order or at participating retailers. This benefit does not carry over to the next period.
Podiatry services - Medicare-covered	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.
Routine Dental (limitations and exclusions apply)	Plan does not have max allowance for Preventive dental services Plan covers up to $4,000 per year for Comprehensive dental services One (1) X-Ray covered every year Unlimited Non-Routine services, Diagnostic services, Restorative services, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgeries, and Other Comprehensive services are covered every year	Plan covers up to $4,000 per year for Preventive and Comprehensive Dental services One (1) X-Ray covered every 12 to 36 months One (1) Non-Routine service covered once per day to 60 months One (1) Diagnostic service covered every year One (1) Restorative service covered every 12 to 84 months Endodontics covered once per tooth One (1) Periodontic service covered every 6 to 36 months Extractions covered once per tooth One (1) Prosthodontic covered every 12 to 84 months One (1) Other Oral/Maxillofacial Surgery covered every 12 to 60 months

Cost	2021 (this year)	2022 (next year)
		or per lifetime One (1) Other Comprehensive service covered every 6 to 60 months
Routine Hearing (limitations and exclusions apply)	Plan has no max allowance You pay a $0 copay per Hearing Aid.	Plan covers up to $2,000 per year for hearing aids, $1,000 per ear You pay a $0 copay per Hearing Aid
Routine Vision (limitations and exclusions apply).	Plan covers up to $300 every year Upgrades are not covered	Plan covers up to $300 every year Upgrades are covered You pay a $0 copay for Lenses, Frames, and Upgrades
Special supplemental benefits for the chronically ill	Special supplemental benefits for the chronically ill are not covered	You must meet eligibility guidelines for the following plan benefits. Additionally, participation in a care management program with our plan may be required. Assistive Devices: You pay a $0 copay. If eligible, you may receive up to $50 each calendar quarter to purchase items on a plan approved list of assistive devices. At the end of each calendar quarter, any unused benefit dollars will roll over to the next period. Please note that unused benefit dollars will expire at the end of each year. Utility Flex Card: You pay a $0 copay. If eligible, the plan offers a prepaid Visa debit card with a limit of $50 per month to help cover the cost of utilities for your home. Any unused Utility Flex Card benefit dollars will

Cost	2021 (this year)	2022 (next year)
		expire at the end of each month. The approved utility services for this benefit include: - Electric, gas, sanitary, and water utilities - Landline telephone service - Cable TV service - Certain petroleum expenses Robotic Companion Pet: You pay a $0 copay. If eligible, you may receive an interactive companion cat or dog from the plan's contracted vendor. Type of pet is subject to availability. Benefit is limited to one pet per member per year.
Non-Emergency Medical Transportation	You pay a $0 copay for 30 trips every year. A trip is considered one-way transportation by taxi, bus/subway, van, medical transport, or rideshare services to a plan approved health-related location. Mileage limits may apply. You must call 72 hours in advance to schedule a trip.	You pay a $0 copay for 24 trips every year. A trip is considered one-way transportation by taxi, van, or rideshare services to a plan approved health-related location. Trips are limited to 75 miles one-way. You must call 72 hours in advance to schedule a trip.
Urgently needed services	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is not covered.	You pay a $0 copay for each Medicare-covered service. Telehealth for this service is covered.
Urgently needed services - Worldwide urgent care coverage	Worldwide urgent care coverage is not covered.	You pay a $120 copay for each covered service. Copayment is not waived if you are admitted to a hospital.

Cost	2021 (this year)	2022 (next year)
Urgently needed services - Worldwide urgent care coverage	Worldwide urgent care coverage is not covered.	You are covered for up to $50,000 every year for emergency and urgently needed services outside the United States.
Virtual Visits	You pay $0 copay per call. Your telehealth services from Teladoc do not include nutritional counseling.	You pay $0 copay per call to Teladoc. Your telehealth services from Teladoc include nutritional counseling.
Prior Authorizations	The following in-network benefits may require prior authorization: • Ambulance services • Ambulatory surgical center • Diabetic services and supplies • Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic procedures and tests • Outpatient diagnostic tests and therapeutic services and supplies - Lab services • Durable medical equipment (DME) and related supplies • Home health agency care • Inpatient hospital care • Inpatient mental health care • Medicare Part B prescription drugs - Chemotherapy/Radiation drugs • Medicare Part B prescription drugs- Part B drugs • Outpatient rehabilitation services - Occupational therapy	The following in-network benefits may require prior authorization: • Additional Telehealth Services • Ambulance services • Ambulatory surgical center • Chiropractic services • Comprehensive dental services • Diabetic services and supplies • Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic procedures and tests • Outpatient diagnostic tests and therapeutic services and supplies - Lab services • Durable medical equipment (DME) and related supplies • Medicare-covered Eye Exams • Medicare-covered Eyewear • Hearing aids • Medicare-covered Hearing Exams • Home health agency care • Inpatient hospital care • Inpatient mental health care

Cost	2021 (this year)	2022 (next year)
	• Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic radiological services • Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services • Outpatient diagnostic tests and therapeutic services and supplies - Therapeutic radiological services • Outpatient hospital observation • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital services • Outpatient substance abuse services • Partial hospitalization services • Outpatient rehabilitation services - Physical therapy and speech-language pathology • Prosthetic devices and related supplies • Skilled nursing facility (SNF) care • Diabetic Therapeutic Shoes and Inserts	• Medicare Part B prescription drugs - Chemotherapy/Radiation drugs • Medicare Part B prescription drugs- Part B drugs • Outpatient rehabilitation services - Occupational therapy • Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic radiological services • Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services • Outpatient diagnostic tests and therapeutic services and supplies - Therapeutic radiological services • Outpatient hospital observation • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital services • Outpatient substance abuse services • Partial hospitalization services • Outpatient rehabilitation services - Physical therapy and speech-language pathology • Preventive dental services • Prosthetic devices and related supplies • Skilled nursing facility (SNF) care • Special Supplemental Benefits for the Chronically Ill

Cost	2021 (this year)	2022 (next year)
		• Transportation (additional routine) • Routine eye exam • Routine Eyewear • Routine hearing exam • Hearing Aid Fitting/Evaluation(s) • Diabetic Therapeutic Shoes and Inserts

Section 2.6— Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call member services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call member services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

- Perhaps you can find a different drug covered by the plan that might work just as well for you. You can check the formulary on our website or call member services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

- You and your doctor can also ask the plan to make an exception for you and continue to cover the drug. You can ask for an exception in advance for next year and we will give you an answer to your request before the change takes effect. There are certain requirements that must be met. To learn what you must do to ask for an exception, see the Evidence of Coverage. The *Evidence of Coverage* is available on our website at www.wellcare.com/allwellnv or you can call member services to request that a copy be mailed to you. Refer to Chapter 9 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*. If you received a favorable formulary exception during 2021, you may not need to obtain a new formulary exception in 2022. At the time of the approval, we would have indicated in the approval notice how long the authorization is valid.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about 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 called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" if you haven't received this insert by September 30, 2021, please call member services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) drugs until you have reached the yearly deductible.	The deductible is $445. During this stage, you pay $0 cost sharing for drugs on Tier 1: Preferred Generic Drugs and the full cost of drugs on Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs, and Tier 5: Specialty Tier until you have reached the yearly deductible. Your deductible amount is either $0 or $92 depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $480. During this stage, you pay $0 cost sharing for drugs on Tier 1: Preferred Generic Drugs and $0 cost sharing for drugs on Tier 6: Select Care Drugs and the full cost of drugs on Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs, and Tier 5: Specialty Tier until you have reached the yearly deductible. Your deductible amount is either $0 or $99 depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply, at a network pharmacy that offers preferred cost sharing, or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Drug Tier 1 - Preferred Generic Drugs:** You pay a $0 copay per prescription. **Drug Tier 2 - Generic Drugs:** You pay a $20 copay per prescription. **Drug Tier 3 - Preferred Brand Drugs:** You pay a $47 copay per prescription. **Drug Tier 4 - Non-Preferred Drugs:** You pay 50% of the total cost. **Drug Tier 5 - Specialty Tier:** You pay 25% of the total cost. **Drug Tier 6 - Select Care Drugs:** Not applicable _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	**Drug Tier 1 - Preferred Generic Drugs:** You pay a $0 copay per prescription. **Drug Tier 2 - Generic Drugs:** You pay a $13 copay per prescription. **Drug Tier 3 - Preferred Brand Drugs:** You pay a $42 copay per prescription. **Drug Tier 4 - Non-Preferred Drugs:** You pay 47% of the total cost. **Drug Tier 5 - Specialty Tier:** You pay 25% of the total cost. **Drug Tier 6 - Select Care Drugs:** You pay a $0 copay per prescription. _____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

The information in the Administrative Changes grid below reflects year over year changes to your plan that do not directly impact benefits or cost-shares.

Description	2021 (this year)	2022 (next year)
Referrals	No referral required	The following in-network benefits may require referrals: • Meal benefit • Special Supplemental Benefits for the Chronically Ill

SECTION 4 Deciding Which Plan to Choose

Section 4.1— If you want to stay in Wellcare Dual Access USHS (HMO D-SNP)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Wellcare Dual Access USHS (HMO D-SNP).

Section 4.2— If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see

Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Wellcare Dual Access USHS (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Wellcare Dual Access USHS (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact member services if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
  - *– or –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 5 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in

every state. In Nevada, the SHIP is called Nevada State Health Insurance Assistance Program (SHIP).

Nevada State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Nevada State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

You can call Nevada State Health Insurance Assistance Program (SHIP) at 1-800-307-4444 (TTY users should call 711). You can learn more about Nevada State Health Insurance Assistance Program (SHIP) by visiting their website (http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/).

For questions about your Nevada Medicaid benefits, contact Nevada Medicaid, 1-877-638-3472 (TTY 711) 8 a.m. - 5 p.m. PT, Monday - Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Nevada Medicaid coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help,"also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Nevada has a program called Nevada Senior Rx Program that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 6 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through The Ryan White HIV/AIDS Program Part B (RWHAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call The

Ryan White HIV/AIDS Program Part B (RWHAP), at 1-775-684-4000 (TTY 711) from 8 a.m. - 5 p.m. local time, Monday - Friday.

SECTION 8 Questions?

Section 8.1— Getting Help from Wellcare Dual Access USHS (HMO D-SNP)

Questions? We're here to help. Please call member services at 1-833-717-0806. (TTY only, call 711.) We are available for phone calls. Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for Wellcare Dual Access USHS (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.wellcare.com/allwellnv. You may also call member services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.wellcare.com/allwellnv. As a reminder, our website has the most up-to-date information about our provider network (Provider & Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 8.2— Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people

with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 8.3— Getting Help from Medicaid

To get information from Medicaid you can call Nevada Medicaid at 1-877-638-3472. TTY users should call 711 from 8 a.m. - 5 p.m. PT, Monday - Friday.

ATENCIÓN: Si habla español, contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. Llame al número de Servicios para Miembros que se indica para su estado en la página siguiente.

注意：如果您説中文，您可以免費獲得語言援助服務。請撥打針對您所在州列示於下一頁的會員服務部電話號碼。

Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí dành cho quý vị. Hãy gọi số điện thoại của bộ phận Dịch Vụ Thành Viên thuộc bang của quý vị ở trang tiếp theo.

주의사항: 한국어를 구사할 경우, 언어 보조 서비스를 무료로 이용 가능합니다. 다음 페이지에서 가입자의 주에 해당하는 목록 내 가입자 서비스부 번호로 전화해 주십시오.

Atensyon: Kung nagsasalita ka ng Tagalog, may mga available na libreng tulong sa wika para sa iyo. Tumawag sa numero ng Mga Serbisyo para sa Miyembro na nakalista para sa iyong estado sa susunod na page.

Dumngeg: No agsasau ka iti Ilokano, dagiti tulong nga serbisio, a libre, ket available para kaniam. Awagam iti numero dagiti serbisio iti Miembro a nakalista para iti estadom iti sumaruno a panid.

La Silafia: Afai e te tautala i le gagana Samoa, o lo’o avanoa ia te oe ‘au’aunaga fesoasoani i le gagana, e leai se totogi. Vala’au le Member Services numera lisiina mo lou setete i le isi itulau.

Maliu: Ke walaʻau Hawaiʻi ʻoe, loaʻa ke kōkua ma ka unuhi ʻōlelo me ke kāki ʻole. E kelepona i ka helu kelepona o ka Māhele Kōkua Hoa i hōʻike ʻia no kou mokuʻāina ma kēia ʻaoʻao aʻe.

We're Just a **Phone Call Away**

ARKANSAS
HMO, HMO D-SNP
1-855-565-9518
Or visit **www.wellcare.com/allwellAR**

ARIZONA
HMO, HMO C-SNP , HMO D-SNP
1-800-977-7522
Or visit **www.wellcare.com/allwellAZ**

CALIFORNIA
HMO, HMO C-SNP, HMO D-SNP, PPO
1-800-275-4737
Or visit **www.wellcare.com/healthnetCA**

FLORIDA
HMO D-SNP
1-877-935-8022
Or visit **www.wellcare.com/allwellFL**

GEORGIA
HMO
1-844-890-2326

HMO D-SNP
1-877-725-7748
Or visit **www.wellcare.com/allwellGA**

INDIANA
HMO, PPO
1-855-766-1541

HMO D-SNP
1-833-202-4704
Or visit **www.wellcare.com/allwellIN**

KANSAS
HMO, PPO
1-855-565-9519

HMO D-SNP
1-833-402-6707
Or visit **www.wellcare.com/allwellKS**

LOUISIANA
HMO
1-855-766-1572

HMO D-SNP
1-833-541-0767
Or visit **www.wellcare.com/allwellLA**

MISSOURI
HMO
1-855-766-1452

HMO D-SNP
1-833-298-3361
Or visit **www.wellcare.com/allwellMO**

MISSISSIPPI

HMO

1-844-786-7711

HMO D-SNP

1-833-260-4124

Or visit **www.wellcare.com/allwellMS**

NEBRASKA

HMO, PPO

1-833-542-0693

HMO D-SNP, PPO D-SNP

1-833-853-0864

Or visit **www.wellcare.com/NE**

NEVADA

HMO, HMO C-SNP, PPO

1-833-854-4766

HMO D-SNP

1-833-717-0806

Or visit **www.wellcare.com/allwellNV**

NEW MEXICO

HMO, PPO

1-833-543-0246

HMO D-SNP

1-844-810-7965

Or visit **www.wellcare.com/allwellNM**

NEW YORK

HMO, HMO-POS, HMO D-SNP

1-800-247-1447

Or visit
www.fideliscare.org/wellcaremedicare

OHIO

HMO, PPO

1-855-766-1851

HMO D-SNP

1-866-389-7690

Or visit **www.wellcare.com/allwellOH**

OKLAHOMA

HMO. PPO

1-833-853-0865

HMO D-SNP

1-833-853-0866

Or visit **www.wellcare.com/OK**

OREGON

HMO, PPO

1-844-582-5177

Or visit **www.wellcare.com/healthnetOR**

HMO D-SNP

1-844-867-1156

Or visit **www.wellcare.com/trilliumOR**

PENNSYLVANIA

HMO, PPO

1-855-766-1456

HMO D-SNP

1-866-330-9368

Or visit **www.wellcare.com/allwellPA**

SOUTH CAROLINA

HMO, HMO D-SNP

1-855-766-1497

Or visit **www.wellcare.com/allwellSC**

TEXAS

HMO

1-844-796-6811

HMO D-SNP

1-877-935-8023

Or visit **www.wellcare.com/allwellTX**

WASHINGTON

PPO

1-844-582-5177

Or visit **www.wellcare.com/healthnetOR**

WISCONSIN

HMO D-SNP

1-877-935-8024

Or visit **www.wellcare.com/allwellWI**

TTY FOR ALL STATES: 711

HOURS OF OPERATION

October 1 to March 31: Monday–Sunday, 8 a.m. to 8 p.m.

April 1 to September 30: Monday–Friday, 8 a.m. to 8 p.m.