2022
Summary of Benefits

Nevada

Wellcare Dual Access USHS (HMO D-SNP)

H6446 | 015

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

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

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

Who can join?

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

Our service area includes these counties in Nevada: Clark and Nye.

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

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

Understanding Dual Eligibility

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

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

Medicare Savings Program (MSP) Levels

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

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

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

What is "Extra Help?"

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

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

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

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

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

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

Which doctors, hospitals and pharmacies can I use? Wellcare Dual Access USHS (HMO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers. You can save money by using our preferred mail-order pharmacy and by using providers in the plan's network. With some plans if you use providers

that are not in our network, your share of the costs for covered services may be higher.

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

For more information, please call us at 1-866-277-6583 (TTY users should call 711). Hours are Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m. Visit us at www.wellcare.com/allwellNV.

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

Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Service Area	Our service area includes these counties in Nevada: Clark and Nye.
Special Needs Plans Eligibility Criteria	This plan includes (FBDE, QMB, QMB+). Refer to "Medicare Savings Program (MSP) Levels" at the beginning of this document
Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive	
Monthly plan premium You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.	$0
Deductible	No deductible
Maximum out-of-Pocket Responsibility (does not include prescription drugs)	$3,450 annually This is the most you will pay in copays and coinsurance for Part A and B services for the year.
Inpatient Hospital coverage	Days 1-90: $0 copay per stay *
Outpatient Hospital coverage	
Outpatient hospital services	$0 copay for surgical and non-surgical services *
Outpatient hospital observation services	$0 copay *

Services with an asterisk (*) may require prior authorization.
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Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Ambulatory surgical center (ASC)	$0 copay *
Doctor Visits Primary Care Providers	 $0 copay
Specialists	$0 copay
Preventive Care (e.g., Annual Wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular screenings, Cervical and vaginal cancer screening, Colorectal cancer screenings, Diabetes screenings, Hepatitis B Virus Screening, Prostate cancer screenings (PSA), Vaccines (including Flu shots, Hepatitis B shots, Pneumococcal shots))	$0 copay
Emergency care	$0 copay
Worldwide emergency coverage	$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. The copay is not waived if admitted to the hospital for Worldwide Emergency Services.
Urgently needed services	$0 copay

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Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Worldwide urgent care coverage	$120 copay Worldwide Emergency and worldwide urgently needed services are subject to a $50,000 maximum plan coverage. The copay is not waived if admitted to the hospital for Worldwide Urgently Needed Services.
Diagnostic Services/Labs/Imaging	COVID-19 testing and specified testing-related services at any location are $0.
Lab services	$0 copay *
Diagnostic tests and procedures	$0 copay *
Outpatient X-rays	$0 copay *
Diagnostic radiology services (e.g. MRI, CAT Scan)	$0 copay *
Therapeutic Radiology	$0 copay *
Hearing services Hearing Exam Medicare Covered	$0 copay *
Routine hearing exam	$0 copay * 1 exam every year

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Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Hearing Aids	
Hearing Aid Fitting/Evaluation(s)	$0 copay * 1 fitting(s) / evaluation(s) every year
Hearing aid allowance	Up to a $2,000 allowance for both ears combined every year for hearing aids.
All types	$0 copay * Limited to 2 hearing aid(s) every year
Additional Hearing Information	**What you should know** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment.
Dental services	
Preventive services	$0 copay * Cleanings 2 every year Dental x-rays 1 every 12 to 36 months Oral exams 2 every year
Fluoride Treatment	$0 copay * 1 every year
Comprehensive services	
Medicare Covered	$0 copay for each Medicare-covered service *

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Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Diagnostic Services	$0 copay * 1 diagnostic service(s) every year
Restorative Services	$0 copay * 1 restorative service(s) every 12 to 84 months
Endodontics/ Periodontics/ Extractions	$0 copay * 1 endodontic service(s) per tooth 1 periodontic service(s) every 6 to 36 months 1 extraction(s) per tooth
Non-routine services	$0 copay * 1 non-routine service(s) every day to 60 months
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	$0 copay * 1 Prosthodontic procedure every 12 to 84 months 1 Oral Maxillofacial procedure every 12 to 60 months or per lifetime 1 Other service every 6 to 60 months
Additional Dental Information	**What you should know:** This plan includes coverage of preventive and comprehensive services up to $4,000.
Vision Services	
Eye Exam Medicare Covered	$0 copay (Medicare-covered diabetic retinopathy screening) $0 copay (all other Medicare-covered eye exams) *

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Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Routine eye exam (Refraction)	$0 copay * 1 exam every year
Glaucoma screening	$0 copay for each Medicare-covered service.
Eyewear Medicare Covered	$0 copay *
Routine eyewear Contact lenses/Eyeglasses (lenses and frames)/Eyeglass frames Eyewear allowance	 $0 copay Unlimited contacts every year Unlimited glasses (lenses and/or frames) every year * Up to a $300 combined allowance every year.
Mental Health Services Inpatient visit	 Days 1-90: $0 copay per stay *
Outpatient individual therapy visit	$0 copay
Outpatient group therapy visit	$0 copay
Skilled nursing facility (SNF)	Days 1-100: $0 copay per benefit period. *

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Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Therapy and Rehabilitation Services Physical Therapy	$0 copay *
Outpatient rehabilitation services provided by an occupational therapist	$0 copay *
Pulmonary rehabilitation services	$0 copay
Ambulance Ground Ambulance	$0 copay *
Air Ambulance	$0 copay *
Transportation Services	Up to 24 one-way trips every year to plan-approved health-related locations. Mileage limits may apply. $0 copay (per one-way trip) * **What you should know:** The first step to staying healthy is getting to your doctor. That's why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need, when you need it. Call Customer Service 72 hours in advance to reserve a ride for your appointment. Mileage limitations may apply.
Medicare Part B Drugs Chemotherapy drugs	$0 copay *

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Benefits

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Other Part B drugs	$0 copay *

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Prescription Drug Coverage	**Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015**
Stage 1: Annual Prescription Deductible	
Deductible	This plan has no deductible for Part D covered drugs, this payment stage doesn't apply.
Stage 2: Initial Coverage (after you pay your deductible, if applicable)	
You pay the following until your total yearly drug costs reach $4,430. The cost share you pay depends on your level of "Extra Help". Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.	
Standard Retail cost-sharing (30-day/90-day supply)	
	Standard
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 4 (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%

Prescription Drug Coverage	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
	Standard
Tier 5 (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15% Limited to 30 day supply
Tier 6 (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%

Prescription Drug Coverage	**Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015**	
Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)		
Mail-order cost-sharing (30-day/90-day supply)		
	Preferred	**Standard**
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 copay	$0 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 4 (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Tier 5 (Specialty Tier - includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15% Limited to 30 day supply	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15% Limited to 30 day supply

Prescription Drug Coverage	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015	
	Preferred	**Standard**
Tier 6 (Select Care Drugs - includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).)	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%	Generics: $0 / $1.35 / $3.95 / 15% Brands: $0 / $4.00 / $9.85 / 15%
Stage 3: Coverage Gap		
	After your total drug costs (including what our plan has paid and what you have paid) reach $4,430, you will pay your "Extra Help" cost share or no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.	
Stage 4: Catastrophic Coverage		
	After your yearly out-of-pocket drug costs (not including what the plan has paid, but including drugs you purchased through your retail pharmacy and through mail order) reach $7,050, depending on your level of “Extra Help” you pay nothing or: • $3.95 copay for generics (including brand drugs treated as generic), or • $9.85 copay for all other drugs	

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

Excluded Drugs:

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

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

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

Additional Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Chiropractic Services Medicare-covered	$0 copay *
Acupuncture Medicare-covered	$0 copay *
Podiatry Services (Foot Care) Medicare Covered	$0 copay **What you should know:** Foot exams and treatments are available if you have diabetes-related nerve damage and/or meet certain conditions.
Virtual Visits	Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors via Teladoc to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more. A virtual visit (also known as a telehealth consult) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.
Home health agency care	$0 copay *

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Additional Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Meals Post-Acute Meals	$0 copay for each post-acute meal ▪ **What you should know:** You pay nothing for post-acute meals immediately following an Inpatient hospital stay to aid in recovery with a maximum of 3 meals per day for up to 14 days.
Chronic Meals	$0 copay for each chronic meal ▪ **What you should know:** You pay nothing for home delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modifications. Members receive 3 meals per day for up to 28 days per month, for a maximum of 84 meals. The benefit can be received for up to 3 months.
Medical Equipment/Supplies Durable Medical Equipment (DME)	$0 copay *
Prosthetics	$0 copay *
Diabetic supplies	$0 copay *
Diabetic therapeutic shoes or inserts	$0 copay *
Opioid treatment program services	$0 copay

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Additional Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
Over-the-Counter (OTC) Items	$0 copay The maximum total benefit is $195 every three months **What you should know:** Members may purchase eligible items from participating locations or through the plan's catalog for delivery to their home.
Wellness Programs Fitness	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. $0 copay Coverage includes: Activity Tracker and Physical Fitness **What you should know:** This benefit covers an annual membership at a participating health club or fitness center. For members who do not live near a participating fitness center and/or prefer to exercise at home, members can choose from available exercise programs to be shipped to them at no cost. A Fitbit or Garmin fitness tracker may be selected as part of a home fitness kit.
Additional sessions of smoking and tobacco cessation counseling	$0 copay Limited to 5 visit(s) every year
24-Hour Nurse Advice Line	$0 copay
Personal emergency medical response device (PERS)	$0 copay
Special Supplemental Benefits for Chronically Ill (SSBCI) To qualify for these benefits you must meet specific criteria, including having a qualifying chronic condition and determined to be eligible for high-risk care	Assistive Devices: You pay $0 copay Plan covers up to $50 per quarter for plan approved list of assistive devices to aid in day-to-day living. Limitations apply. Robotic Companion: You pay $0 copay Covers an interactive companion cat or dog from a contracted provider. Limitations apply.

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Additional Benefits

	Wellcare Dual Access USHS (HMO D-SNP) H6446, Plan 015
management. For a complete list of eligibility criteria, please see the Evidence of Coverage.	Utility Flex Card: You pay $0 copay Plan covers up to $50 per month to help cover the cost of utilities for your home. Limitations apply. Referral may be required *
Flex Card	$1,000 yearly benefit **What you should know:** The Flex Card benefit is a debit card that may be used to reduce out of pocket costs at a dental, vision or hearing providers that accepts the card carrier.

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Comprehensive Written Statement for Prospective Enrollees

The benefits described in the Premium and Benefit section of the Summary of Benefits are covered by our Medicare Advantage plan. For each benefit listed, you can see what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. Coverage of the benefits described in this Summary of Benefits depends upon your level of Medicaid eligibility. No matter what your level of Medicaid eligibility is,
Allwell Dual Medicare Harmony P3 (HMO D-SNP) will cover the benefits described in the Premium and Benefit section of the Summary of Benefits. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Nevada Medicaid toll-free at 1-877-638-3472 (TTY: 711).

Our source of information for Medicaid benefits is https://www.medicaid.nv.gov/contactinfo.aspx. All Medicaid covered services are subject to change at any time. For the most current Nevada Medicaid coverage information, please visit https://www.medicaid.nv.gov/contactinfo.aspx or call Member Services for assistance. A detailed explanation of Nevada Medicaid benefits can be found in the Nevada Summary of Services online at https://www.medicaid.nv.gov/contactinfo.apx

What Benefits Are Covered?
• Ambulance/Emergency Transportation
• Birth Control/Family Planning
• Dental (most adults - emergency care only; qualified pregnant women - some periodontal benefits; children - full coverage & limited orthodontia)
• Disposable Medical Supplies
• Durable Medical Equipment
• Doctor Visits
• Emergency Room
• Eye Exams and Eyeglasses
• Healthy Kids (preventive health services for children to age 21)
• Hearing Tests
• Home Health Care
• Hospice Care
• Hospital Care
• Lab and Radiology Services
• Maternity Care
• Mental Health/ Substance Abuse Services
• Midwife Services
• Nursing Home Services
• Nutritionist
• Occupational Therapy Services

What Benefits Are Covered?
• Orthotics & Prosthetics
• Over-the-Counter Drugs with a Prescription
• Personal Care Services
• Physical Therapy Services
• Podiatry
• Prescription Drugs
• Preventive Screenings
• Private Duty Nursing
• Specialists
• Speech and Hearing Services
• Tobacco Cessation
• Transportation Services (Non-emergency transportation is not a NCU benefit.)
• Vaccines
• Waiver Programs - help people with special needs (elderly/people with physical and intellectual disabilities, for example) stay in their communities. Eligibility requirements must be met and services are not an entitlement (not a regular benefit).

This Section gives you more information about benefits.

Ambulance/Emergency Transportation

In you have a medical emergency, call 911 for an ambulance. Medicaid and NCU (Nevada Check Up) will cover air and ground ambulance services in an emergency.

Birth Control & Family Planning

Talk to your doctor or clinic about family planning. You can get family planning services from any provider who accepts Medicaid and NCU. You do not need a referral. You may get some types of birth control in your doctor's office. For others, your doctor will write a prescription. These forms of birth control are covered by Medicaid and NCU:

- Birth control pills
- Condoms
- Creams
- Diaphragms
- Foams
- IUDs
- Shots (ex. Depo-Provera)
- Sponges

Dental Benefits

Adults (Medicaid only): Emergency, palliative, some prosthetic care; qualified pregnant women—adult benefits and some expanded benefits. Children (under 21) get full coverage, with some (limited) orthodontia. Dentists need prior approval from Medicaid or NCU for some of the benefits.

Disposable Medical Supplies, Durable Medical Equipment, Orthotics & Prosthetics

Medicaid and NCU cover many medical supplies that are ordered by your doctor for a medical reason. For example, some supplies which may be covered are:

- Incontinent supplies (adult diapers)
- Wheelchair, canes, crutches and walkers
- Prosthetic orthotic devices
- Wound care supplies
- Insulin pump
- Oxygen

Talk to your doctor if you need medical supplies. Your doctor may write a prescription for you to take to a medical supply company. The medical supplier must get prior approval from Medicaid and NCU for some items.

Doctor Visits

Medicaid and NCU pay for you to see a doctor or visit an Urgent Care Clinic when you are having health problems. It is important for you to see your primary care physician whenever possible for regular treatment so he/she has an updated medical history. If needed, your doctor may refer you to a specialist.

Emergency Room

Call 911 in an emergency, or go to the emergency room right away. You will need to call your doctor when the emergency is over. Your doctor must provide any follow up care you need after the emergency. If it is not an emergency and your primary care provider is not available, go to an urgent care clinic.

Eye Exams and Eyeglasses

Medicaid/NCU covers care for eye diseases, eye surgery that is medically necessary, eye exams and prescription eyeglasses. Medicaid pays for eye exams and eyeglasses only once every 12 months. Your provider will show you frames you may choose from that are covered in full. If you choose more expensive frames, you must pay the difference between what Medicaid and NCU pay and the cost of the frames you've chosen. Make sure you sign an agreement in advance if you are going to pay for more expensive frames. Medicaid/NCU does not cover contact lenses, except under certain cases when they are medically necessary.

Healthy Kids or Early Periodic Screening Diagnosis and Treatment (EPSDT)

Healthy Kids, also known as EPSDT, is a special benefit for children on Medicaid/NCU. Some problems start before your child looks or feels sick. Your doctor can find and treat these problems early, before they become serious, with regular “well-child” exams. Healthy Kids also covers dental check-ups. Almost everyone from birth through age 20 who gets Medicaid/NCU can get Healthy Kids-covered services. These services include:

- Well-child exams by your child’s doctor. This is a head-to-toe exam including health history, eating habits, vision and hearing exams, mental health evaluation and a growth and development check;
- Shots (vaccines) to keep your child healthy;
- Dental checkups. A complete exam and cleaning (covered through age 20) twice a year, or more often if your child’s dentist recommends it;
- Fluoride treatment and sealants;
- Follow-up treatment and care if a health problem is found during an exam;
- Lead testing and other laboratory tests; and
- If needed, free transportation to any Medicaid-approved medical appointments. (Does not apply to NCU recipients.)

When should your child have a well-child exam?

- Newborns – as soon as possible after birth
- Infants – at one, two, four, six, nine and 12, 15, 18, 24, and 30 months
- Toddlers to young adults (3-20 years old) every year

Hearing Tests

Newborn hearing tests are included in the newborn hospital stay. Childhood hearing tests are part of a Healthy Kids/EPSDT exam. Other hearing tests are covered for both children and adults, if they are medically necessary.

Home- and Community-based Services

These services help you receive the medical care you need so you can stay in your home. They include adult day health care, personal care services, home health care, private-duty nursing and partial hospitalization. These services are for people who need assistance because they have ongoing mental health illnesses. If you need these services, you will need to have an evaluation to make sure you or your loved one meets the eligibility requirements and that they are medically necessary.

Home Health Care

Home health care is for people who need special, in-home services like skilled nursing, physical therapy, occupational therapy or speech therapy. If you think you need home health care, talk to your doctor. Your doctor will submit an order to a home health agency of your choice who is enrolled with Medicaid. The home health agency will contact Medicaid or NCU for prior approval.

Hospice Care

Hospice services can give you or a family member support and comfort when someone is at the end of their life. The hospice takes care of your physical, emotional and spiritual needs in a specialized hospice facility, a nursing facility, an Intermediate Care Facility (ICF) or in your home. Different kinds of specialists can help your family deal with the final stages of illness, dying and grieving.

Hospital Care

Both inpatient and outpatient hospital care are covered. Before you use hospital services, get a referral from your doctor.

Lab and Radiology Services

Lab and radiology (X-ray) services are covered; they may be done in your doctor's office, or your doc-tor may refer you to another clinic, lab or hospital.

Maternity Care

If you think you are pregnant, see a doctor as soon as possible. Early maternity care will help you give birth to a healthy baby. You may choose to see a specialist such as an Obstetrical/ Gynecological (OB/GYN) physician or a certified nurse midwife. Medicaid covers medically necessary Caesarian-sections but does not pay for C-sections done for the convenience of the mother or the physician. Covered services include:

- Prenatal visits, lab work and necessary tests (such as ultrasound)
- The hospital stay
- Labor and delivery
- The second- and/or sixth-week checkup after the birth
- Anesthesia (pain treatment)
- Birth control/family planning

You can stay in the hospital up to 72 hours after a normal birth and up to 96 hours after a C-section. You can choose a shorter stay if you and your doctor agree. Your baby may be covered by Medicaid for the first year of life if you are able to get Medicaid when your baby is born. Contact your DWSS caseworker as soon as possible to report the birth of your baby.
For your baby to be covered for NCU services from their birth, you must notify DWSS within 14 days of the delivery. If you have temporary coverage for the newborn and they are qualified for NCU, coverage will begin the first day of the next administrative month. For example, if your baby is born on September 15, and the mother has other insurance coverage for 30 days (until October 15), the newborn would not be enrolled in NCU until November 1. Your newborn cannot receive coverage which predates another family member's earliest current enrollment. Your child can stay covered by NCU if the parent meets the income requirement yearly, keeps premium payments current and the child meets other eligibility requirements.

Midwife Services

You may choose to use a midwife during your pregnancy. You must choose a certified and licensed midwife who is a Medicaid or NCU provider. Some certified midwives can deliver babies in a birthing center or in the hospital, in case of an emergency during delivery.

Mental Health/Substance Abuse Services

These are benefits you may receive to treat an acute (short-term) or chronic (continuing for a long time) behavioral health disorder. Some of these services include:

- Inpatient/Outpatient services
- Psychiatric evaluations
- Medication management
- Psychological testing
- Inpatient alcohol/substance abuse detoxification services
- Individual and group therapy
- Emergency hospital care
- Crisis intervention
- Outpatient alcohol/substance abuse detoxification services

Nursing Home Services

Nursing facilities provide health care services on a 24-hour basis to people who have medical problems or injuries that cannot be managed at home. If you or a family member has cognitive impairments (problems with things like memory, perception, judgment and reasoning) or behavioral impairments, a nursing facility can provide help. This assistance can help you with medical care, nursing care, rehabilitative services and psychosocial management or a combination of those services.

Out-of-state nursing facility services are offered to residents when:

- You cannot be placed in a Nevada nursing facility;
- You live on or near a Nevada border and it is more practical for you to receive medical service from an out-of-state provider.

Occupational Therapy

Occupational therapy helps improve your medical condition or helps you learn or relearn a task after serious illnesses, injuries or disabilities. Your doctor’s order must be submitted to an occupational therapist who accepts Medicaid or NCU.

Over-the-counter Drugs

If your doctor prescribes them, you can get over-the-counter medicines, like antacids, aspirin, acetaminophen, and medicine for coughs, colds and allergies. Take the prescription to the pharmacy and Nevada Medicaid will pay for the medicine.

Personal Care Services

The Personal Care Services program helps people with disabilities or long-lasting illnesses live independently in their home. These services are for people who do not have someone legally responsible to help them. A Personal Care Attendant (PCA) helps people with tasks like bathing, dressing and toileting, and may also help with making meals, shopping for essential things like food, laundry and light housekeeping. The type of service and number of hours allowed are based on medical need. A physical or occupational therapist will do an evaluation.

Physical Therapy

You can get physical therapy for some serious illnesses, injuries or disabilities if it will improve your medical condition. It must be ordered by your doctor, who will authorize a physical therapist who accepts Medicaid or NCU.

Prescription Drugs

Medicaid and NCU cover many prescription drugs. Some prescriptions require prior authorization. There is a list of preferred drugs for your physician to choose from. Prescriptions for weight loss and drugs you use for cosmetic and experimental reasons are not covered. If you are on Medicare and Medicaid, most of your prescriptions must be provided by Medicare. Medicaid will cover the items Medicare may not cover, including some over-the-counter medications.

Private Duty Nursing

Private duty nursing can help you get more individual and continuous care than you would from a visiting nurse. The program helps you stay safely at home rather than in a facility like a nursing home. You must have a doctor's order for private duty nursing.

Speech & Hearing Services

If you have serious speech or hearing problems, see your doctor. Your doctor may refer you to a speech therapist or an audiologist. Some services covered by Medicaid or NCU are:

- Hearing tests
- Hearing aids
- Hearing aid batteries
- Speech therapy

Tobacco Cessation

Products to help you stop using tobacco are covered. You must get a prescription from your doctor and take it to a pharmacy. Prescription and over-the-counter medication like patches and lozenges are covered. So is tobacco-cessation counseling, as part of an office visit to your doctor.

Transportation Services (non-emergency)

Medicaid provides rides to medical appointments, called Non-Emergency Transportation (NET). This service is provided through a transportation company that Medicaid contracts with. Transportation is not covered for NCU recipients. You can get rides to be treated for a Medicaid-covered service. You should arrange for rides at least five days in advance. The company may help you get public transportation. For urgent care trips, the transportation company must provide you with a ride on the same day you call. If you have to cancel your doctor's appointment, please remember to cancel your transportation. The doctor's office will not cancel it for you.
Prior Authorization by the transportation company is required.

Vaccines

All medically recommended childhood and adult vaccines are covered.

Waiver Programs

If you have special needs, you may qualify for more benefits through waiver programs. Waivers allow Medicaid to pay for support and services to help you, and as a result may enable you to live safely in your own home or community rather than in a nursing facility or other institution. Waiver services include:

- Emergency response systems
- Homemaker services
- Group homes
- Day treatment centers
- Adult day care
- Family support
- Home-delivered meals
- Respite care for family members who need a break from caring for disabled or elderly family members

These programs are for people who meet the program requirements, like those who are aged or who have physical or intellectual disabilities. There is a set number of people who can be on these programs. For information about how to apply for one of the waiver programs, call the Medicaid District Office in your area.

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：如果您說中文，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**

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1-855-565-9518
Or visit **www.wellcare.com/allwellAR**

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

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

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

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

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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

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

OREGON

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1-844-582-5177

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

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1-844-867-1156

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

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HMO, PPO

1-855-766-1456

HMO D-SNP

1-866-330-9368

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

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HMO, HMO D-SNP

1-855-766-1497

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

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HMO

1-844-796-6811

HMO D-SNP

1-877-935-8023

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

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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.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-277-6583 (TTY: 711). Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday-Friday, 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Visit www.wellcare.com/allwellnv or call 1-866-277-6583 (TTY: 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

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

Contact Us

For more information, please contact us:

By phone

Toll-free at 1-866-277-6583 (TTY 711). Your call may be answered by a licensed agent.

Hours of Operation

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

Online www.wellcare.com/allwellNV

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

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