2022
Summary of Benefits

Ohio

Wellcare Value Script (PDP)

S4802 | 149

Wellcare Classic (PDP)

S4802 | 085

Wellcare Medicare Rx Value Plus (PDP)

S4802 | 217

This is a summary of prescription drug benefits covered by Wellcare Value Script (PDP), Wellcare Classic (PDP), and Wellcare Medicare Rx Value Plus (PDP) from January 1, 2022 to December 31, 2022.

A Prescription Drug Plan (PDP) is one option for individuals who want to enroll in the Medicare Part D prescription drug coverage, which subsidizes the costs of prescription drugs for enrollees. A prescription drug plan (PDP) is a stand-alone plan, covering only prescription drugs.

Who can join?

To join one of our plans, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B and live in our service area.

Our service area includes this state: Ohio.

Which drugs are covered?

Our plans use a formulary. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website (www.wellcare.com/PDP). Or, call us and we will send you a copy of the formulary.

Which pharmacies can I use?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plans' pharmacy directory at our website (www.wellcare.com/PDP). Or, call us and we will send you a copy of the pharmacy directory.

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible, if applicable: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

For more information, please contact your plan for details.

This document does not list every service, limitation or exclusion. A complete list of services is in the plan’s Evidence of Coverage. You can find the Evidence of Coverage on our website at www.wellcare.com/PDP. Or you may call us to ask for a copy at the phone number listed on the back cover.

For coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. You can access or view it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. Available 24 hours, 7 days a week, including some federal holidays.

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.

Prescription Drug Coverage	Wellcare Value Script (PDP) S4802, Plan 149	Wellcare Classic (PDP) S4802, Plan 085	Wellcare Medicare Rx Value Plus (PDP) S4802, Plan 217
Monthly plan premium	$12.90	$28.80	$68.90
Stage 1: Annual Prescription Deductible			
Deductible	$480 for Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) Part D prescription drugs. For all other covered drugs, you will not have to pay any deductible and will start receiving coverage immediately.	$480 for all covered Part D prescription drugs.	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. 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.			
Retail cost-sharing (30-day/90-day supply)			

	Preferred	Standard	Preferred	Standard	Preferred	Standard
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 / $0 copay	$8 / $24 copay	$0 / $0 copay	$5 / $15 copay	$0 / $0 copay	$10 / $30 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	$4 / $12 copay	$15 / $45 copay	$7 / $21 copay	$15 / $45 copay	$4 / $12 copay	$20 / $60 copay

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	Preferred	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	$42 / $126 copay	$47 / $141 copay	$40 / $120 copay	$47 / $141 copay	$47 / $141 copay	$47 / $141 copay
	Tier 3, select insulin cost sharing is $35 a month for a 30-day supply of each medication during the deductible, initial coverage and coverage gap stages. See your plan's Evidence of Coverage for complete details.		N/A		Tier 3, select insulin cost sharing is $35 a month for a 30-day supply of each medication during the initial coverage and coverage gap stages. See your plan's Evidence of Coverage for complete details.	
Tier 4 (Non-Preferred Drugs - includes non-preferred brand and non-preferred generic drugs.)	47% / 47% coinsurance	50% / 50% coinsurance	35% / 35% coinsurance	36% / 36% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance
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.)	25% coinsurance / Not Available	25% coinsurance / Not Available	25% coinsurance / Not Available	25% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available

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Stage 2: Initial Coverage (after you pay your deductible, if applicable) (Continued)						
Mail-order cost-sharing (30-day/90-day supply)						
	Preferred	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic Drugs - includes preferred generic drugs and may include some brand drugs.)	$0 / $0 copay	$8 / $24 copay	$0 / $0 copay	$5 / $15 copay	$0 / $0 copay	$10 / $30 copay
Tier 2 (Generic Drugs - includes generic drugs and may include some brand drugs.)	$4 / $12 copay	$15 / $45 copay	$7 / $21 copay	$15 / $45 copay	$4 / $10 copay	$20 / $60 copay
Tier 3 (Preferred Brand Drugs - includes preferred brand drugs and may include some generic drugs.)	$42 / $126 copay	$47 / $141 copay	$40 / $120 copay	$47 / $141 copay	$47 / $117.50 copay	$47 / $141 copay
	Tier 3, select insulin cost sharing is $35 a month for a 30-day supply of each medication during the deductible, initial coverage and coverage gap stages. See your plan's Evidence of Coverage for complete details.		N/A		Tier 3, select insulin cost sharing is $35 a month for a 30-day supply of each medication during the initial coverage and coverage gap stages. See your plan's Evidence of Coverage for complete details.	

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	Preferred	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**
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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.)	25% coinsurance / Not Available	25% coinsurance / Not Available	25% coinsurance / Not Available	25% coinsurance / Not Available	33% coinsurance / Not Available	33% coinsurance / Not Available
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 no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.		After your total drug costs (including what our plan has paid and what you have paid) reach $4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.		After your total drug costs (including what our plan has paid and what you have paid) reach $4,430, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.	

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	Preferred	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**
Stage 4: Catastrophic Coverage						
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% coinsurance, or • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% coinsurance, or • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% coinsurance, or • $3.95 copay for generic (including brand drugs treated as generic) and a $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).

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

注意：如果您説中文，您可以免費獲得語言援助服務。請致電 1-877-374-4056 (TTY：711)。

Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí dành cho quý vị. Hãy gọi số 1-877-374-4056 (TTY: 711).

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

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

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

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

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

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-293-5151 (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/pdp or call 1-888-293-5151 (TTY: 711) to view a copy of the EOC.
- ☐ 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.

Contact Us

For more information, please contact us:

By phone

Toll-free at 1-888-293-5151 (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/PDP

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.