Today's Options® PFFS

A WellCare Company

Medicare&More

2018 PRODUCT OVERVIEW

CONFIDENTIAL – FOR AGENT USE ONLY NOT INTENDED FOR THE INSURANCE BUYING PUBLIC

Kit 1 – Maine and New York

Today's Options® PFFS is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options® PFFS depends on contract renewal. A Private Fee-for-Service plan is not Medicare supplement insurance. Providers who do not contract with our plan are not required to see you except in an emergency.

For agent use only. Plan designs and service areas described in this document are pending CMS approval and are subject to change. Plans contain exclusions and limitations. This document may not be shared. Distribution to consumers, other insurers, or any other person or company is strictly prohibited.

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2018 Benefit Highlights - Maine and New York

Effective January 1, 2018– December 31, 2018

PLAN BENEFITS - PFFS	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)		TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)		TODAY'S OPTIONS PREMIER 300 (PFFS)		TODAY'S OPTIONS PREMIER 200 (PFFS)	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Monthly Plan Premium[1]	$25.00		$124.00		$0.00		$62.00	
MEDICAL COVERAGE								
DOCTOR OFFICE VISITS								
Primary Care Physician	$10 Copay	$25 Copay	$0 Copay	$10 Copay	$5 Copay	$15 Copay	$0 Copay	$10 Copay
Physician Specialist	$35 Copay	$60 Copay	$25 Copay	$35 Copay	$30 Copay	$50 Copay	$25 Copay	$35 Copay
INPATIENT CARE								
Inpatient Hospital Care	$295 Copay per day (Days 1 - 5) $0 Copay per day (Days 6 and beyond)	$300 Copay per day (Days 1 - 7) $0 Copay per day (Days 8 and beyond)	$500 Copay per stay	$300 Copay per day (Days 1 - 7) $0 Copay per day (Days 8 and beyond)	$260 Copay per day (Days 1 - 6) $0 Copay per day (Days 7 and beyond)	$300 Copay per day (Days 1 - 7) $0 Copay per day (Days 8 and beyond)	$500 Copay per stay	$300 Copay per day (Days 1 - 7) $0 Copay per day (Days 8 and beyond)
Skilled Nursing Facility (SNF)	$0 Copay per day (Days 1 - 20) $165 Copay per day (Days 21 - 100)	$0 Copay per day (Days 1 - 20) $250 Copay per day (Days 21 - 100)	$0 Copay per day (Days 1 - 20) $150 Copay per day (Days 21 - 100)	$0 Copay per day (Days 1 - 20) $200 Copay per day (Days 21 - 100)	$0 Copay per day (Days 1 - 20) $165 Copay per day (Days 21 - 100)	$0 Copay per day (Days 1 - 20) $250 Copay per day (Days 21 - 100)	$0 Copay per day (Days 1 - 20) $150 Copay per day (Days 21 - 100)	$0 Copay per day (Days 1 - 20) $200 Copay per day (Days 21 - 100)
OUTPATIENT SERVICES								
Ambulatory Surgical Center Services	$250 Copay	30% of the cost	$150 Copay	30% of the cost	$200 Copay	30% of the cost	$150 Copay	30% of the cost
Outpatient Hospital Services	$300 Copay	30% of the cost	$200 Copay	30% of the cost	$250 Copay	30% of the cost	$200 Copay	30% of the cost
Diabetes Testing Supplies Preferred	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Diabetes Testing Supplies Non-Preferred	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost
Durable Medical Equipment	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost
Home Health Care	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost

[1]You must continue to pay your Medicare Part B premium.

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PLAN BENEFITS - PFFS	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)		TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)		TODAY'S OPTIONS PREMIER 300 (PFFS)		TODAY'S OPTIONS PREMIER 200 (PFFS)	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
LAB SERVICES AND OTHER TESTS[2]								
Laboratory Tests	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Therapeutic Radiology Services (such as radiation treatment for cancer)	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost
Diagnostic Radiology Services (such as MRIs, CT scans)	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost	20% of the cost	30% of the cost
Outpatient X-Rays	$15 Copay	30% of the cost	$15 Copay	30% of the cost	$15 Copay	30% of the cost	$15 Copay	30% of the cost
EMERGENCY SERVICES[3]								
Ambulance Services	$300 Copay	$300 Copay	$300 Copay	$300 Copay	$300 Copay	$300 Copay	$300 Copay	$300 Copay
Emergency Care	$80 Copay	$80 Copay	$100 Copay	$100 Copay	$80 Copay	$80 Copay	$100 Copay	$100 Copay
Urgently Needed Care	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay
Worldwide Emergency	20% of the cost $20,000 Benefit Maximum	20% of the cost $20,000 Benefit Maximum	20% of the cost $20,000 Benefit Maximum	20% of the cost $20,000 Benefit Maximum	20% of the cost $20,000 Benefit Maximum	20% of the cost $20,000 Benefit Maximum	20% of the cost $20,000 Benefit Maximum	20% of the cost $20,000 Benefit Maximum
PREVENTIVE CARE								
Annual Wellness Visit	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Breast Cancer Screening	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Cardiovascular Screening	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Colorectal Cancer Screening	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Prostate Cancer Screening	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Bone Mass Measurement	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Diabetes Screening	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Flu & Pneumonia Vaccine	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Glaucoma Screening	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
Mammogram Screening	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost

[2]Medicare-approved lab work.
[3]There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. There is also no coverage for medication purchases while outside of the United States.

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	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
ANNUAL MAXIMUM OUT-OF-POCKET								
Yearly limit on your out-of-pocket costs for medical and hospital care	$6,700 Combined		$3,400 Combined		$6,700 Combined		$3,400 Combined	
ADDITIONAL BENEFITS (NOT COVERED BY ORIGINAL MEDICARE)								
VISION SERVICES								
Annual Vision Exam	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost
HEARING SERVICES								
Annual Hearing Exam	$20 Copay	30% of the cost	$20 Copay	30% of the cost	$20 Copay	30% of the cost	$20 Copay	30% of the cost
WELLNESS PROGRAM								
24/7 Health Hotline	Speak with a registered nurse (RN) 24 hours a day		Speak with a registered nurse (RN) 24 hours a day		Speak with a registered nurse (RN) 24 hours a day		Speak with a registered nurse (RN) 24 hours a day	
ANNUAL PHYSICAL EXAM								
Comprehensive head-to-toe physical examination and evaluation	$0 Copay	$25 Copay	$0 Copay	$10 Copay	$0 Copay	$15 Copay	$0 Copay	$10 Copay
MEDICAL NUTRITIONAL THERAPY								
Additional nutritional counseling services for certain conditions such as diabetes, renal disease, and obesity	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost	$0 Copay	30% of the cost

PRESCRIPTION DRUG COVERAGE	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)		TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)		TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
PRESCRIPTION DRUG DEDUCTIBLE	$0		$0		Prescription Drug Coverage not offered in this plan.	Prescription Drug Coverage not offered in this plan.
INITIAL COVERAGE STAGE	You pay the following until your total yearly drug cost reaches $3,750:		You pay the following until your total yearly drug cost reaches $3,750:			
Preferred Retail Cost-Share (In-Network)	30-DAY RETAIL	90-DAY RETAIL	30-DAY RETAIL	90-DAY RETAIL		
Tier 1: Preferred Generic	$2.00 Copay	$5.00 Copay	$0.00 Copay	$0.00 Copay		
Tier 2: Generic	$7.00 Copay	$17.50 Copay	$5.00 Copay	$12.50 Copay		
Tier 3: Preferred Brand	$37.00 Copay	$92.50 Copay	$35.00 Copay	$87.50 Copay		
Tier 4: Non-Preferred Drugs	$90.00 Copay	$225.00 Copay	$75.00 Copay	$187.50 Copay		
Tier 5: Specialty Tier Drugs	33% Coinsurance	Not Available	33% Coinsurance	Not Available		
Standard Retail Cost-Share (In-Network)	30-DAY RETAIL	90-DAY RETAIL	30-DAY RETAIL	90-DAY RETAIL		
Tier 1: Preferred Generic	$7.00 Copay	$17.50 Copay	$5.00 Copay	$12.50 Copay		
Tier 2: Generic	$12.00 Copay	$30.00 Copay	$10.00 Copay	$25.00 Copay		
Tier 3: Preferred Brand	$47.00 Copay	$117.50 Copay	$45.00 Copay	$112.50 Copay		
Tier 4: Non-Preferred Drugs	$100.00 Copay	$250.00 Copay	$85.00 Copay	$212.50 Copay		
Tier 5: Specialty Tier Drugs	33% Coinsurance	Not Available	33% Coinsurance	Not Available		
Mail Order Also Available[4]	90-day supply of prescription drugs by mail for one 30-day copay in Tiers 1 & 2 and two 30-day copays for Tiers 3 & 4					
GAP COVERAGE STAGE						
	After your total yearly drug costs reach $3,750, you will receive a discount and generally pay no more than: • 35% of the plan's costs for brand drugs • 44% of the plan's costs for generic drugs					
CATASTROPHIC COVERAGE STAGE						
	After your yearly out-of-pocket drug costs reach $5,000, you pay the greater of: • $3.35 Copay for generics (including brand drugs treated as generic), OR • $8.35 Copay for all other drugs, OR • 5% Coinsurance					

[4]90-day supply of most Tier 1 and Tier 2 prescription drugs for a 30-day copay; 90-day supply of most Tier 3 and Tier 4 prescription drugs for two 30-day copays. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and copays.

Understanding drug payment stages.
What you need to know.

Deductible Stage

During this stage, **if your plan has a deductible**, you usually pay the full cost of your drugs up to the deductible amount.

Once you reach the deductible amount (if applicable) you pay a copayment or coinsurance in the Initial Coverage Stage.

Initial Coverage Stage

During this stage, the plan pays its share of the cost and you pay your share of the cost (copayment or coinsurance) for each prescription you fill until your total drug costs reach $3,750.

Once this limit is reached, you will enter the Coverage Gap.

Initial: Up to $3,750
Most people will remain in this stage.

Coverage Gap Stage

During this stage you receive limited coverage on certain drugs. You will also receive a discount on brand name drugs and generic drugs until your yearly out-of-pocket drug costs reach $5,000.

Once your out-of-pocket costs reach $5,000, you move to catastrophic coverage.

Gap: Up to $5,000
Some people will move into this stage.

Catastrophic Coverage Stage

In this stage you pay only a small copay or coinsurance amount for each filled prescription.

The plan will pay most of the cost of your drugs for the rest of the calendar year.
- **You will pay $3.35 or 5% of the cost for generic drugs (whichever is greater).**
- **You will pay $8.35 or 5% of the cost for name brand drugs (whichever is greater).**

Catastrophic:
Through the end of the year
Few people reach this stage.

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For additional information, please contact UAM Sales Support at: **1-855-225-1475**, Monday – Friday, 8:30 a.m. to 5:00 p.m. Eastern Time, or visit us on the web at **www.TodaysOptions.com**

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WellCare® Health Plans