*1118116619 *

WellCare Health Plans
PO Box 31378
Tampa, FL, 33631-3378

**PAULA D PHILLIPS**
**202 MIDWAY DR**
**MARIETTA, SC 29661-9507**

MONTHLY REPORT

# Medical and Hospital Claims Processed in

For PAULA D PHILLIPS
Member ID: 18294995

## This is not a bill:

- This monthly report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. We send a separate report on Part D prescription drugs if applicable.
- If you notice something suspicious that might be dishonest billing, you can report it by calling **1-800-MEDICARE (1-800-633-4227)**, 8am-8pm, 7 days a week. (TTY users should call **711**.) If you are covered by more than one (1) health benefit plan, you should file all your claims with each plan.

WellCare Health Plans, Inc., is an HMO, PPO, PFFS plan with a Medicare contract. Enrollment in our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments and restrictions may apply. Benefits, premiums and/or co-payments/coinsurance may change on January 1 of each year.

www.wellcare.com/medicare

### Customer Services

If you have questions, call us at **1-866-892-8340** (TTY **711)**

We are here Monday - Sunday (4/1 through 9/30 representatives are available Monday - Friday) from 8am to 8pm. Español: **1-866-892-8340**

How healthy is your heart? It's important to get screened each year to maintain longterm heart health. Call the Toll-Free Number on the back of your card if you need assistance with scheduling an appointment with your doctor.

| **TOTALS for medical and hospital claims** | Amount providers have billed the plan | Total Cost (amount the plan has approved) | **Plan's Share** | **Your Share (Co-pays/ Coinsurance)** |
|---|---|---|---|---|
| **Totals for this month** (for claims processed from , through 31,) | $1,801.80 | $174.20 | $174.20 | $0.00 |
| **Totals for** (all claims processed through 31, ) | $1,801.80 | $174.20 | $174.20 | $0.00 |

## YEARLY LIMIT - this limit gives you financial protection

This limit tells the most you will have to pay in Jan in "out-of-pocket" costs (copays, coinsurance, and your deductible) for medical and hospital services covered by the plan.

This yearly limit is called your "out-of-pocket maximum." It puts a limit on how much you have to pay, but it does not put a limit on how much care you can get. This means:

- Once you have reached your limit in out-of-pocket costs, **you stop paying out of pocket for all services**.
- You keep getting your covered medical and hospital services as usual, and **the plan will pay the full cost for the rest of the year.**

As of 01/31/Jan**, you have had** $51.06 **in out-of-pocket costs** that count toward your $5,900.00 out-of-pocket maximum for covered services.

*NOTE: To describe the services you received, this report uses billing codes and descriptions that were developed and copyrighted by the American Medical Association (all rights reserved).*

## Details for Claims Processed in

| Look over the information about your claims - does it seem correct? | You have the right to make an appeal or complaint | Remember, this report is NOT A BILL: |
|---|---|---|
| • If you have questions or think there might be a mistake, start by calling the doctor's office or other service provider. Ask them to explain the claim.<br>• If you still have questions, call us at Customer Service **1-866-892-8340** (TTY **711**). | • Making an appeal is a formal way of asking us to *change our decision* about your coverage. You can make an appeal if we deny a claim. You can also make an appeal if we approve a claim but you disagree with how much you are paying for the item or services. For information about making an appeal, call us at Member Services (phone numbers are in a box on page 1). | • If you have not already paid the amount shown for "your share" *wait until you get a bill* from the provider.<br>**If you get a bill that is *higher* than the amount shown for "your share" call us at Customer Services 1-866-892-8340 (TTY 711).** |

| **NEW HORIZON FAMILY WEST END MED ALLIANCE** Claim Number: **1267540059** (In-Network provider) | Date of Service | Amount the provider billed the plan | Quantity the provider billed the plan | Total Cost (amount the plan approved) | **Plan's Share** | Line Reference | **Your Share (Co-pay/ Coinsurance** |
|---|---|---|---|---|---|---|---|
| RURAL/CLINIC (G0467) | 01/08/21 | $162.81 | 1 | $162.81 | $157.81 | 0 | $5.00 |
| RURAL/CLINIC (99214) | 01/08/21 | $129.00 | 1 | $0.00 **DENIED Provider Billing Error (See Below)** | $0.00 | 0 | $0.00 |
| RURAL/CLINIC (3077F) | 01/08/21 | $0.00 | 1 | $0.00 | $0.00 | 0 | $0.00 |
| RURAL/CLINIC (3079F) | 01/08/21 | $0.00 | 1 | $0.00 | $0.00 | 0 | $0.00 |
| RURAL/CLINIC (3046F) | 01/08/21 | $0.00 | 1 | $0.00 | $0.00 | 0 | $0.00 |
| See Note 2 below | **TOTALS:** | $291.81 | | $162.81 | $157.81 | | $5.00 |

| **LABORATORY CORP OF AMERICA**<br>Claim Number: **1267149307**<br>(In-Network provider) | Date of Service | Amount the provider billed the plan | Quantity the provider billed the plan | Total Cost (amount the plan approved) | **Plan's Share** | Line Reference | **Your Share (Co-pay/ Coinsurance** |
|---|---|---|---|---|---|---|---|
| MICROALBUMIN, QUANTITATIVE (82043) | 01/08/21 | $68.14 | 1 | $4.86 | $4.86 | 0 | $0.00 |
| ASSAY OF URINE CREATININE (82570) | 01/08/21 | $60.86 | 1 | $4.35 | $4.35 | 0 | $0.00 |
| COMPLETE CBC W/AUTO DIFF WBC (85025) | 01/08/21 | $31.00 | 1 | $6.52 | $6.52 | 0 | $0.00 |
| COMPREHEN METABOLIC PANEL (80053) | 01/08/21 | $46.00 | 1 | $8.87 | $8.87 | 0 | $0.00 |
| LIPID PANEL (80061) | 01/08/21 | $98.00 | 1 | $11.24 | $11.24 | 0 | $0.00 |
| GLYCOSYLATED HEMOGLOBIN TEST (83036) | 01/08/21 | $66.00 | 1 | $8.15 | $8.15 | 0 | $0.00 |
| ASSAY THYROID STIM HORMONE (84443) | 01/08/21 | $94.00 | 1 | $14.11 | $14.11 | 0 | $0.00 |
| | **TOTALS:** | $464.00 | | $58.10 | $58.10 | | $0.00 |

| **PRISMA HEALTH NORTH GREENVILLE LTACH**<br>Claim Number: **1265335451**<br>(In-Network provider) | Date of Service | Amount the provider billed the plan | Quantity the provider billed the plan | Total Cost (amount the plan approved) | **Plan's Share** | Line Reference | **Your Share (Co-pay/ Coinsurance** |
|---|---|---|---|---|---|---|---|
| LABORATORY (36415) | 12/29/20 | $31.00 | 1 | $0.00 **DENIED Provider Billing Error (See Below)** | $0.00 | 0 | $0.00 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| LAB/IMMUNOLOGY (86200) | 12/29/20 | $175.00 | 1 | $0.00 **DENIED Provider Billing Error (See Below)** | $0.00 | 0 | $0.00 |
| LAB/IMMUNOLOGY (86431) | 12/29/20 | $84.00 | 1 | $0.00 **DENIED Provider Billing Error (See Below)** | $0.00 | 0 | $0.00 |
| LAB/HEMATOLOGY (85651) | 12/29/20 | $95.00 | 1 | $0.00 **DENIED Provider Billing Error (See Below)** | $0.00 | 0 | $0.00 |
| DX X-RAY (73030) | 12/29/20 | $1,152.00 | 1 | $78.18 | $78.18 | 0 | $0.00 |
| See Note 2 below | **TOTALS:** | $1,537.00 | | $78.18 | $78.18 | | $0.00 |

| **JAMES A EPLING** Claim Number: **1263309499** (In-Network provider) | Date of Service | Amount the provider billed the plan | Quantity the provider billed the plan | Total Cost (amount the plan approved) | **Plan's Share** | Line Reference | **Your Share (Co-pay/ Coinsurance** |
|---|---|---|---|---|---|---|---|
| X-RAY EXAM OF SHOULDER (73030) | 12/29/20 | $35.00 | 1 | $9.81 | $9.81 | 0 | $0.00 |
| | **TOTALS:** | $35.00 | | $9.81 | $9.81 | | $0.00 |

| **JAMES A EPLING** Claim Number: **1263276949** (In-Network provider) | Date of Service | Amount the provider billed the plan | Quantity the provider billed the plan | Total Cost (amount the plan approved) | **Plan's Share** | Line Reference | **Your Share (Co-pay/ Coinsurance** |
|---|---|---|---|---|---|---|---|
| X-RAY EXAM OF SHOULDER (73030) | 12/29/20 | $35.00 | 1 | $9.81 | $9.81 | 0 | $0.00 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **TOTALS:** | $35.00 | | $9.81 | $9.81 | | $0.00 |

| **JOHN P COTTER**<br>Claim Number: **1262279913**<br>(In-Network provider) | Date of Service | Amount the provider billed the plan | Quantity the provider billed the plan | Total Cost (amount the plan approved) | **Plan's Share** | Line Reference | **Your Share (Co-pay/ Coinsurance** |
|---|---|---|---|---|---|---|---|
| INFLUENZA ASSAY W/OPTIC (87804) | 12/03/20 | $40.80 | 2 | $0.00 **DENIED Provider Billing Error (See Below)** | $0.00 | 0 | $0.00 |
| See Note 2 below | **TOTALS:** | $40.80 | | $0.00 | $0.00 | | $0.00 |

| **PRISMA HEALTH GREENVILLE MEMORIAL HOSPIT**<br>Claim Number: **1249967924**<br>(In-Network provider) | Date of Service | Amount the provider billed the plan | Quantity the provider billed the plan | Total Cost (amount the plan approved) | **Plan's Share** | Line Reference | **Your Share (Co-pay/ Coinsurance** |
|---|---|---|---|---|---|---|---|
| LABORATORY (C9803) | 12/05/20 | $58.00 | 1 | $22.52 | $22.52 | 0 | $0.00 |
| LAB/BACT-MIRCO (87635) | 12/05/20 | $96.00 | 1 | $53.88 | $53.88 | 0 | $0.00 |
| | **TOTALS:** | $154.00 | | $76.40 | $76.40 | | $0.00 |

Optional Supplemental Services: Details for claims processed in **/**
(Amounts for optional supplemental services are not included in the totals shown on page 2)

**Things to know about your denied claim:**

Note 2

**NOTE: We have denied all or part of this claim.** However, you are not responsible for paying the billed amount because you received this service from a WellCare Health Plans provider OR based on a referral from a WellCare Health Plans provider.

# Multi-Language Insert
# Multi-language Interpreter Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-374-4056** (TTY: **1-877-247-6272**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-374-4056** (TTY: **1-877-247-6272**).

注意：如果您使用繁醴中文，您可以免赞狸得捂言援助服粉。睛致霉 **1-877-374-4056 (TTY: 1-877-247-6272)** 。

CHÚ Ý: Nếu ban nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-374-4056** (TTY: **1-877-247-6272**).

주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1−877−374−4056 (TTY: 1−377−247−6272) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-374-4056** (TTY: **1-877-247-6272**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-374-4056 (телетайп: 1-877-247-6272).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-374-4056 (رقم هاتف الصم والبكم: 1-877-247-6272).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-374-4056 (TTY: 1-877-247-6272).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le **1-877-374-4056** (TTY: **1-877-247-6272**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-374-4056** (TTY: **1-877-247-6272**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-374-4056** (TTY: **1-877-247-6272**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-374-4056** (TTY: **1-877-247-6272**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **1-877-374-4056** (TTY: **1-877-247-6272** ）まて、お電話にてご連絡ください。

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ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-374-4056** (TTY: **1-877-247-6272**).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-877-374-4056** (TTY: **1-877-247-6272**) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-374-4056** (TTY: **1-877-247-6272**) पर कॉल करें।.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-877-374-4056** (TTY (հեռատիպ)՝ **1-877-247-6272**):

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-374-4056** (TTY: **1-877-247-6272**).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-374-4056 (TTY: 1-877-247-6272).

اردو بولیں، ہیں تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-877-374-4056** (TTY: **1-877-247-6272**) اگر آپ:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-877-374-4056** (TTY: **1-877-247-6272**) 'ਤੇ ਕਾਲ ਕਰੋ।

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-877-374-4056** (TTY: **1-877-247-6272**)।

אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-**877-374-4056** (TTY: **1-877-247-6272**).

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-877-374-4056** (TTY: **1-877-247-6272**).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል: ወደ ሚከተለው ቁጥር ይደውሉ **1-877-374-4056** (መስማት ለተሳናቸው: **1-877-247-6272**).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-374-4056** (TTY: **1-877-247-6272**).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-374-4056 (TTY: 1-877-247-6272).

Wann du [Deitsch (Pennsylvania German/Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-877-374-4056** (TTY: **1-877-247-6272**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-374-4056** (TTY: **1-877-247-6272**).

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PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti **1-877-374-4056** (TTY: **1-877-247-6272**).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-877-374-4056 (TTY: 1-877-247-6272).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-374-4056 (TTY: 1-877-247-62TI)..

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-374-4056** (TTY: **1-877-247-6272**)

УВАГА! Якщо ви розмовляЕте українською мовою, ви можете звернутися до безкоштовної служби мовноУ підтримки. Телефонуйте за номером **1-877-374-4056** (телетайп: **1-877-247-6272**).

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्तभिाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877-374-4056 (टटिविाइ: 1-877-247-6272) ।

**LALE: Ñe kwōj kōnono Kajin Ṃajō!, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-877-374-4056 (**TTY: **1-877-247-6272).**

MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-877-374-4056** (TTY: **1-877-247-6272**).

**ENĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1-877-374-4056 (TTY: 1-877-247-6272).**

FAKATOKANGA'I: Kapau 'oku' ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai **1-877-374-4056** (TTY: **1-877-247-6272**).

Ni songen mwohmw ohte, komw pahn sahte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call **1-877-374-4056** (TTY: **1-877-247-6272**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-877-374-4056 (TTY: 1-877-247-62TI).

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-877-374-4056** (TTY: **1-877-247-6272**).

ANOMPA PA PISAH: [Chahta] makilla ish anompoli hokma, kvna hosh Nahollo Anompa ya pipilla hosh ehi tosholahinla. Atoko, hattak yvmma im anompoli ehi bvnnakmvt, holhtina pa payah: **1-877-374-4056** (TTY: **1-877-247-6272**).

DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. I-877-374-4056 (TTY: I-877-247-6272) irtibat numaralarını arayın.

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## Discrimination is Against the Law

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare Health Plans, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact WellCare Customer Service for help or you can ask Customer Service to put you in touch with a Civil Rights Coordinator who works for WellCare.

If you believe that WellCare Health Plans, Inc., has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

WellCare Health Plans, Inc., Grievance Department, P.O. Box 31384, Tampa, FL 33631-3384; Telephone - 1-866-530-9491; TTY number - 1-877-247-6272; Fax: 1-866-388-1769; OperationalGrievance@wellcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a WellCare Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

*** This Nondiscrimination Notice also applies to ‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc., and Easy Choice Health Plan, a WellCare company.**