

Wellcare 'Ohana Dual Align (HMO-POS D-SNP) offered by WellCare Health Insurance of Arizona, Inc. (Wellcare by 'Ohana Health Plan)

Annual Notice of Changes for 2025

You are currently enrolled as a member of Wellcare 'Ohana Dual Align (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.wellcare.com/ohana. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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.
 - Review the changes to medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including coverage restrictions and cost sharing.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
 - Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
 - Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.
- ☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.
- ☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.
- ☐ 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 Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- ☐ 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, 2024, you will stay in Wellcare 'Ohana Dual Align (HMO-POS D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Wellcare 'Ohana Dual Align (HMO D-SNP).
- Look in Section 3, page 16 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Chinese, Korean, Vietnamese, Tagalog, Ilocano, Samoan, Hawaiian, Cambodian, Hmong, Japanese, Lao, and Thai.
- Please contact our Member Services number at 1-888-846-4262 for additional information. (TTY users should call 711.) Hours are: Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m. Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day. This call is free.
- 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 'Ohana Dual Align (HMO-POS 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. The plan also has a written agreement with the Hawaii Medicaid program to coordinate your Medicaid benefits.
 - When this document says “we,” “us,” or “our,” it means WellCare Health Insurance of Arizona, Inc. When it says “plan” or “our plan,” it means Wellcare 'Ohana Dual Align (HMO-POS D-SNP).
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Wellcare 'Ohana Dual Align (HMO-POS D-SNP) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher 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	For covered admissions, per admission: \$0 copay for each covered hospital stay	For covered admissions, per admission: \$0 copay for each covered hospital stay
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: \$0 Copayment during the Initial Coverage Stage: You pay a \$0 copay for all covered Part D drugs. Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Deductible: \$0 Copayment during the Initial Coverage Stage: You pay a \$0 copay for all covered Part D drugs. Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From network providers: \$8,850 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.	From network providers: \$9,350 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.

SECTION 1 We Are Changing the Plan’s Name

On January 1, 2025, our plan name will change from Wellcare 'Ohana Dual Align (HMO D-SNP) to Wellcare 'Ohana Dual Align (HMO-POS D-SNP).

You will receive a new ID Card in the mail that displays the new plan name on or before December 31, 2024. Going forward, all other communications regarding your 2025 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	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Hawaii Med-QUEST Division Program (Medicaid).)	\$0	\$0

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

Medicare requires all health plans to limit how much you pay out-of-pocket for 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	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount	\$8,850	\$9,350
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.		Once you have paid \$9,350 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 and Pharmacy Networks

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.

Updated directories are located on our website at www.2025wellcaredirectories.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider & Pharmacy Directory* www.2025wellcaredirectories.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Provider & Pharmacy Directory* www.2025wellcaredirectories.com to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – 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 making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Out-of-Network Point-of-Service (POS) Coverage: Routine dental benefits	There is no out-of-network POS benefit.	Out-of-network routine (non-Medicare-covered) dental services <u>only</u> are covered through your POS benefit. The routine dental benefit limits, if any, are combined between in-network and out-of-network providers. Your out-of-pocket costs may be higher when you use out-of-network dentist. Out-of-network dental providers are not contracted to accept plan payment as payment in full. If they charge you more than what the Plan pays, you are responsible for the difference, even for services that have \$0 copay.
Routine dental services - Comprehensive dental services - Diagnostic and Preventive Dental Services	Diagnostic dental services are covered under comprehensive dental services.	Diagnostic dental services are covered under diagnostic and preventive dental services.
Routine dental services - Comprehensive dental services	Up to a \$3,000 allowance for in-network covered comprehensive dental services every year.	Up to a \$3,000 allowance for all in-network and out-of-network covered comprehensive dental services every year.
Out-of-Network Point-of-Service (POS) Coverage: Routine comprehensive dental benefits	There is no out-of-network POS benefit.	Out-of-Network You pay 25% of the total cost for covered comprehensive dental services received from an out-of-network provider.
Routine dental services - Diagnostic and Preventive Dental Services - Other Diagnostic Services	Limited to 1 other diagnostic service(s) every year.	Limited to 1 other diagnostic service(s) every day to 1 year.

Cost	2024 (this year)	2025 (next year)
Routine dental services - Comprehensive dental services - Oral and Maxillofacial Surgery	Limited to 12 to 60 months or per lifetime or once per tooth per lifetime depending on the type of covered services.	Limited to 1 oral and maxillofacial surgeries per lifetime depending on type of service.
Routine dental services - Comprehensive dental services - Prosthodontics - fixed	Limited to 1 prosthodontic fixed service(s) every 12 to 84 months depending on type of service.	Limited to 1 prosthodontic fixed service(s) every 7 years depending on type of service.
Out-of-Network Point-of-Service (POS) Coverage: Routine diagnostic and preventive dental benefits	There is no out-of-network POS benefit.	Out-of-Network You pay 25% of the total cost for covered preventive dental services received from an out-of-network provider.
Routine dental services - Comprehensive dental services - Adjunctive General Services	Limited to 1 adjunctive general service(s) every day to 60 months depending on type of service.	Adjunctive dental services periodicities range from per date of service to unlimited visits depending on the type of service.
Routine dental services - Comprehensive dental services - Prosthodontics - removable	Limited to 1 prosthodontic, removable service(s) every 12 to 84 months depending on type of service.	Limited to 1 prosthodontic, removable service(s) every 6 months to 5 years depending on type of service.
Routine dental services - Diagnostic and Preventive Dental Services - Other Preventive Dental services	Limited to 1 other preventive dental service(s) every 6 to 60 months depending on type of service.	Limited to 1 other preventive dental services(s) every day to 1 year depending on type of service.
Emergency care - Worldwide Emergency Coverage	You pay a \$100 copay for each covered service. Copayment is <u>not</u> waived if you are admitted to the hospital.	You pay a \$110 copay for each covered service. Copayment is <u>not</u> waived if you are admitted to the hospital.

Cost	2024 (this year)	2025 (next year)
Fitness Benefit	<p>You pay a \$0 copay for the fitness benefit.</p> <p>The fitness benefit includes a fitness center membership at a participating fitness center or a home fitness kit including a wearable fitness tracker. You can receive up to 1 kit per benefit year. Members also have access to a digital fitness program, the 1:1 Healthy Aging Coaching program and the Well-Being Club.</p>	<p>You pay a \$0 copay for the fitness benefit.</p> <p>The fitness benefit includes a fitness center membership at a participating fitness center or a home fitness kit including a wearable fitness tracker. You can receive up to 1 kit per benefit year. Members also have access to digital fitness programs, the 1:1 Well-Being Coaching program and the Well-Being Club.</p>
Nutritional/dietary counseling benefit	You pay a \$0 copay for each individual nutritional/dietary counseling visit.	Nutritional/dietary counseling visits are <u>not</u> covered.
Outpatient mental health care - Non-psychiatric services - Group sessions	<p>You pay a \$0 copay for each Medicare-covered Group Session.</p> <p>Telehealth for this service is <u>not</u> covered.</p>	<p>You pay a \$0 copay for each Medicare-covered Group Session.</p> <p>Telehealth for this service is covered.</p>
Outpatient mental health care - Psychiatric services - Group sessions	<p>You pay a \$0 copay for each Medicare-covered Group Session.</p> <p>Telehealth for this service is <u>not</u> covered.</p>	<p>You pay a \$0 copay for each Medicare-covered Group Session.</p> <p>Telehealth for this service is covered.</p>
Outpatient substance use disorder services - Group sessions	<p>You pay a \$0 copay for each Medicare-covered Group Session.</p> <p>Telehealth for this service is <u>not</u> covered.</p>	<p>You pay a \$0 copay for each Medicare-covered Group Session.</p> <p>Telehealth for this service is covered.</p>
Additional Smoking Cessation	You pay a \$0 copay for each covered service, up to 5 visit(s) every year.	Additional smoking cessation services are <u>not</u> covered.

Cost	2024 (this year)	2025 (next year)
Urgently needed services - Worldwide Urgent Care Coverage	<p>You pay a \$100 copay for each covered service.</p> <p>Copayment is <u>not</u> waived if you are admitted to a hospital.</p>	<p>You pay a \$110 copay for each covered service.</p> <p>Copayment is <u>not</u> waived if you are admitted to a hospital.</p>
<p>Value-Based Insurance Design (VBID) Model</p> <p>Medicare approved Wellcare to provide these benefits as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.</p>	<p>You pay a \$0 copay. You can use your Wellcare Spendables™ allowance towards certain benefits. Home Improvement and safety items are <u>not</u> included.</p> <p>Please see your Evidence of Coverage (EOC) for more information.</p>	<p>You pay a \$0 copay. You can use your Wellcare Spendables™ allowance towards certain benefits. Home Improvement and Safety Items are included.</p> <p>Please see your Evidence of Coverage (EOC) for more information.</p>
Wellcare Spendables™	<p>You pay a \$0 copay. You receive a \$90 monthly allowance to be used towards certain benefits. The maximum benefit is \$1,080 every year.</p> <p>See Value-Based Insurance Design (VBID) Model section in this chart for information about the VBID program benefit changes.</p>	<p>You pay a \$0 copay. You receive a \$99 monthly allowance to be used towards certain benefits.</p> <p>See Value-Based Insurance Design (VBID) Model section in this chart for information about the VBID program benefit changes.</p>

Cost	2024 (this year)	2025 (next year)
Social Support Platform	Social support platform is <u>not</u> a covered benefit.	<p>You pay a \$0 copay for each covered service.</p> <p>Unlimited social support platform services every year.</p> <p>Our plan provides an online social support platform to support your overall well-being. You have access to community, therapeutic activities, and plan-sponsored resources to help manage stress and anxiety. The platform makes it easy for you to join and stay involved to maintain a healthy behavioral health journey. It is available online 24/7, so you can use it whenever you want.</p> <p>Twill platform includes:</p> <ul style="list-style-type: none">• Tailored Well-Being Programs• Peer and Expert Support• Personalized Digital Health Tools <p>Please refer to your Evidence of Coverage for more details.</p>

Section 2.5 – 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, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately add new restrictions.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: <https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients>. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p> <p>Medicare approved Wellcare to provide lower copayments/co-insurance as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans. For more information about VBID benefits, please contact Member Services.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>You pay a \$0 copay per prescription for all covered Part D drugs.</p> <hr/> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>You pay a \$0 copay per prescription for all covered Part D drugs.</p> <hr/> <p>Once you have paid \$2,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Wellcare 'Ohana Dual Align (HMO-POS 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 'Ohana Dual Align (HMO-POS D-SNP).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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 'Ohana Dual Align (HMO-POS 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 'Ohana Dual Align (HMO-POS 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 so.
 - – *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 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Hawaii Med-QUEST Division Program (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.

Because you have Hawaii Med-QUEST Division Program (Medicaid), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare with a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Hawaii Med-QUEST Division Program (Medicaid) benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Hawaii Med-QUEST Division Program (Medicaid)

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Hawaii, the SHIP is called Hawaii State Health Insurance Assistance Program (SHIP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Hawaii 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 Hawaii State Health Insurance Assistance Program (SHIP) at 1-888-875-9229 (TTY users should call 1-866-810-4379). You can learn more about Hawaii State Health Insurance Assistance Program (SHIP) by visiting their website (<http://www.hawaiiiship.org/>).

For questions about your Hawaii Med-QUEST Division Program (Medicaid) benefits, contact Hawaii Med-QUEST Division Program (Medicaid) at 1-800-316-8005 (TTY 711) 7:45 a.m. - 4:30 p.m. HT,

Monday - Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Hawaii Med-QUEST Division Program (Medicaid) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** Because you have Hawaii Med-QUEST Division Program (Medicaid), you are already enrolled in “Extra Help,” also called the Low-Income Subsidy. “Extra Help” pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office.

SECTION 7 Questions?

Section 7.1 – Getting Help from Wellcare 'Ohana Dual Align (HMO-POS D-SNP)

Questions? We're here to help. Please call Member Services at 1-888-846-4262. (TTY only, call 711). We are available for phone calls. Between October 1 and March 31, representatives are available Monday–Sunday, 7:45 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 7:45 a.m. to 8 p.m. Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day. Calls to these numbers are free.

Read your 2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Wellcare 'Ohana Dual Align (HMO-POS 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/ohana. 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/ohana. 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 7.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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 document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) 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 7.3 – Getting Help from Hawaii Med-QUEST Division Program (Medicaid)

To get information from Medicaid you can call Hawaii Med-QUEST Division Program (Medicaid) at 1-800-316-8005 from 7:45 a.m. - 4:30 p.m. HT, Monday - Friday. TTY users should call 711.

Multi-Language Insert
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-888-846-4262 (TTY: 711)**. Someone who speaks English/Language can help you. This is a free service.

Spanish: Contamos con los servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para solicitar un intérprete, llámenos al **1-888-846-4262 (TTY: 711)**. Alguien que hable español puede ayudarlo. Este es un servicio gratuito.

Chinese (Mandarin): 我们提供免费的口译服务，可解答您对我们的健康或药物计划的有关疑问。如需译员，请拨打 **1-888-846-4262 (TTY: 711)**。您将获得中文普通话口译员的帮助。这是一项免费服务。

Chinese (Cantonese): 我們提供免費的口譯服務，可解答您對我們的健康或藥物計劃可能有的任何疑問。如需口譯員服務，請致電 **1-888-846-4262 (TTY: 711)**。會說廣東話的人員可以幫助您。此為免費服務。

Tagalog: May mga libre kaming serbisyo ng interpreter para sagutin ang anumang posible ninyong tanong tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang kami sa **1-888-846-4262 (TTY: 711)**. May makakatulong sa inyo na nagsasalita ng Tagalog. Isa itong libreng serbisyo.

French: Nous mettons à votre disposition des services d'interprétation gratuits pour répondre à toutes vos questions sur notre régime de santé ou de médicaments. Pour obtenir les services d'un interprète, appelez-nous au **1-888-846-4262 (TTY: 711)**. Un interlocuteur francophone pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào của quý vị về chương trình sức khỏe hoặc chương trình thuốc của chúng tôi. Để nhận thông dịch viên, chỉ cần gọi cho chúng tôi theo số **1-888-846-4262 (TTY: 711)**. Một nhân viên nói tiếng Việt có thể giúp quý vị. Dịch vụ này được miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetschservice, wenn Sie Fragen zu unseren Gesundheits- oder Medikamentenplänen haben. Wenn Sie einen Dolmetscher brauchen, rufen Sie uns unter folgender Telefonnummer an: **1-888-846-4262 (TTY: 711)**. Ein deutschsprachiger Mitarbeiter wird Ihnen behilflich sein. Dieser Service ist kostenlos.

Korean: 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우, **1-888-846-4262(TTY: 711)**번으로 당사에 연락해 주십시오. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

Russian: Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, вам доступны бесплатные услуги переводчика. Если вам нужен переводчик, просто позвоните нам по номеру **1-888-846-4262 (TTY: 711)**. Вам окажет помощь сотрудник, говорящий на русском языке. Данная услуга бесплатна.

Arabic: نوَقِّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-888-846-4262 (TTY: 711)**. يمكن أن يساعدك شخص يتحدث العربية. وتتوفر هذه الخدمة بشكل مجاني.

Hindi: हमारे स्वास्थ्य या ड्रग प्लान के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए, हम मुफ्त में दुभाषिया सेवाएं देते हैं। दुभाषिया सेवा पाने के लिए, बस हमें **1-888-846-4262 (TTY: 711)** पर कॉल करें। हिंदी बोलने वाला/वाली कोई सहायक आपकी मदद कर सकता/सकती है। यह एक नि:शुल्क सेवा है।

Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il **1-888-846-4262 (TTY: 711)**. Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte nos através do número **1-888-846-4262 (TTY: 711)**. Um falante de português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan **1-888-846-4262 (TTY: 711)**. Yon moun ki pale Kreyol Ayisyen ka ede w. Se yon sèvis ki gratis.

Polish: Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod numer **1-888-846-4262 (TTY: 711)**. Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

Japanese: 弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、**1-888-846-4262 (TTY: 711)** にお電話ください。日本語の通訳担当者が対応します。これは無料のサービスです。

Chuukese: Mi kawor chon affou ese kame ika mei wor om kapas eis fan iten am kewe kokkotun tumwunun inis ika pekin safei. Ika ka mochen emon chon affou, kokori ei nampa **1-888-846-4262 (TTY: 711)**. Emon mi sine fosun chuuk a tongeni alisuk. Ei angang ese kame.

Hawaiian: Loa‘a iā mākou nā lawelawe unuhi ‘ōlelo manuahi e pane i nā nīnau āu e pili ana i kā mākou papahana olakino a lā‘au paha. No ka loa‘a ‘ana o ka unuhi ‘ōlelo e kelepona iā mākou ma **1-888-846-4262 (TTY: 711)**. Hiki i kekahi kanaka ‘ōlelo Hawai‘i ke kōkua iā ‘oe. He lawelawe manuahi kēia.

Ilocano: Adda iti libre a serbisyo ti panagpatarus mi tapno masungbatan ti anyaman a saludsod mo maipanggep iti plano ti salun-at wenno agas mi. Tapno makaala ti maysa nga agipatpatarus pakiawagan dakami laeng iti **1-888-846-4262 (TTY: 711)**. Mabalín nga makatulong kenka ti maysa nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

Marshallse: Ewōr ad jerbal in ukok ñān uak jabdewōt kajitok emaroñ in wōr am kin būlaan in ejmour ak uno ko rekajur. Ñan am kabbok riukok kall tok ilo **1-888-846-4262 (TTY: 711)**. Juon armej eo ej Kajin Majol emaroñ jibañ eok. Ejelok onean jerbal in.

Samoa: E iai matou auaunaga faamatala upu e tali atu i soo se fesili e te ono fesili ai e uiga ia matou fuafuaga tau soifua maloloina poo fualaa. Ina ia maua se tagata faamatala upu na'o le vili mai a matou i le **1-888-846-4262 (TTY: 711)**. E mafai ona fesoasoani atu ia te oe se tasi e tautala i le gagana Samoan. E leai se totagi o lena auaunaga.

Tongan: 'Oku 'i ai 'emau sēvesi fakatonulea ta'etotongi ke tali ha fa'ahinga fehu'i pē te mou ma'u fekau'aki mo 'emau palani mo'ui lelei pe fo'i'akaú. Ke ma'u ha fakatonulea, tā mai pē ki he **1-888-846-4262 (TTY: 711)**. 'E lava ke tokoni atu ha tokotaha lea Fakatonga. Ko ha sēvesi ta'etotongi 'eni.

Visayan: Duna mi'y libreng serbisyo sa interpreter aron motubag sa bisan unsa nimong mga pangutana bahin sa among health o drug plan. Aron mokuha og interpreter tawagi lang mi sa **1-888-846-4262 (TTY: 711)**. Ang usa ka tawo nga nagsulti og Bisaya makatabang nimo. Libre kini nga serbisyo.

Lao: ພວກເຮົາມີບໍລິການຄົ້ນພາສາພຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບແຜນສຸຂະພາບ ຫຼື ຢາຂອງພວກເຮົາ. ເພື່ອຂໍຄົ້ນແປພາສາ ພຽງແຕ່ໂທຫາພວກເຮົາໄດ້ທີ່ເບີ **1-888-846-4262 (TTY: 711)**. ມີຄົນທີ່ເວົ້າພາສາລາວສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນບໍລິການພຣີ.

Cambodian: យើងមានសេវាកម្មប្រែប្រួលមាត់ដោយឥតគិតថ្លៃសម្រាប់ឆ្លើយរាល់សំណួរដែលអ្នកមានអំពីគម្រោងឱសថ ឬគម្រោងសុខភាពរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែប្រែមាត់ គ្រាន់តែទូរសព្ទមកយើងខ្ញុំតាមរយៈលេខ **1-888-846-4262 (TTY: 711)**។ មនុស្សម្នាក់ដែលនិយាយភាសាខ្មែរបានអាចជួយអ្នកបាន។ នេះជាសេវាកម្មឥតគិតថ្លៃ។

Hmong: Peb muaj cov kev pab cuam kws txhais lus pab dawb los teb cov nqe lus nug twg uas koj yuav muaj hais txog peb lub phiaj xwm duav roos kev noj qab haus huv thiab tshuaj. Yog xav tau ib tug kws txhais lus ces tsuas hu rau peb tau ntawm **1-888-846-4262 (TTY: 711)**. Ib tug neeg twg uas hais tau lus Hmoob yuav pab tau koj. Qhov no yog kev pab cuam pab dawb xwb.

Thai: เรามีบริการล่ามแปลภาษาให้ฟรีเพื่อตอบคำถามใดๆ ที่คุณอาจมีเกี่ยวกับแผนด้านสุขภาพหรือยาของเรา หากต้องการล่ามแปลภาษา โปรดติดต่อเราที่หมายเลข **1-888-846-4262 (TTY: 711)** คนที่พูดภาษาไทยได้สามารถช่วยคุณได้ บริการนี้ไม่มีค่าใช้จ่าย