

## Wellcare Home State Health Dual Access Open (PPO D-SNP) offered by WELLCARE OF MISSOURI HEALTH INSURANCE COMPANY, INC.

### Annual Notice of Change for 2027

You're enrolled as a member of Wellcare Dual Access Open (PPO D-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in Wellcare Home State Health Dual Access Open (PPO D-SNP).
- To change to a **different plan**, visit [Medicare.gov](https://www.Medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [go.wellcare.com/Medicare](https://go.wellcare.com/Medicare) or call Member Services at 1-833-444-9089 (TTY users call 711) to get a copy by mail.

#### More Resources

- Call Member Services at 1-833-444-9089 (TTY users call 711) for more information. 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. This call is free.
- We can send materials to you in a language other than English or in an alternate format (such as braille, audio, or large print). Please call Member Services if you need plan information in another format.

#### About Wellcare Home State Health Dual Access Open (PPO D-SNP)

- Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, 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. Our plan also has a written agreement with the Missouri Medicaid program to coordinate your Medicaid benefits.
- When this material says “we,” “us,” or “our,” it means WELLCARE OF MISSOURI HEALTH INSURANCE COMPANY, INC. When it says “plan” or “our plan,” it means Wellcare Home State Health Dual Access Open (PPO D-SNP).
- On January 1, 2027, our plan name will change from Wellcare Dual Access Open (PPO D-SNP) to Wellcare Home State Health Dual Access Open (PPO D-SNP). We'll send you a new member ID card with our new name. From here on, our new name, Wellcare Home State Health Dual Access Open (PPO D-SNP), will be on all materials.

- **If you do nothing by December 7, 2026, you'll automatically be enrolled in Wellcare Home State Health Dual Access Open (PPO D-SNP).** Starting January 1, 2027, you'll get your medical and drug coverage through Wellcare Home State Health Dual Access Open (PPO D-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2027

|                                                                                                                                                                                                                                                                                                          | 2026<br>(this year)                                                                    | 2027<br>(next year)                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>* Your premium can be higher than this amount. Go to Section 1.1 for details.<br><br>Because you get Extra Help, you do not pay a premium for this plan.                                                                                                                 | \$0                                                                                    | \$0                                                                                                                                                                                                                                |
| <b>Deductible</b><br>If you are eligible for full Medicare cost sharing assistance under MO HealthNet (Missouri Medicaid), you pay \$0. However, out-of-network providers that are not enrolled in your state Medicaid may charge the deductible amount depending on your Medicaid eligibility category. | \$0 or \$283 except for insulin furnished through an item of durable medical equipment | <b>\$0 or \$283 except for insulin furnished through an item of durable medical equipment</b><br><br><b>This is the 2026 Medicare-defined amount and may change for 2027. Please contact Member Services for more information.</b> |

|                                                                                                                                                                                 | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Maximum out-of-pocket amount</b></p> <p>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services.<br/>(Go to Section 1.2 for details.)</p> | <p>From network providers: \$9,250</p> <p>From network and out-of-network providers combined: \$13,900</p> <p>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 received in-network. However, depending on your Medicaid eligibility category, out-of-network providers that are not enrolled in your state Medicaid may charge out-of-pocket cost-sharing that would apply to your maximum out-of-pocket.</p> | <p><b>From network providers: \$9,850</b></p> <p><b>From network and out-of-network providers combined: \$14,800</b></p> <p><b>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 received in-network. However, depending on your Medicaid eligibility category, out-of-network providers that are not enrolled in your state Medicaid may charge out-of-pocket cost-sharing that would apply to your maximum out-of-pocket.</b></p> |
| <b>Primary care office visits</b>                                                                                                                                               | <p><b>In-Network</b><br/>\$0 copay per visit</p> <p><b>Out-of-Network</b><br/>\$0 or 30% of the total cost, depending on your MO HealthNet (Missouri Medicaid) eligibility category, per visit.</p>                                                                                                                                                                                                                                                                                                    | <p><b>In-Network</b><br/><b>\$0 copay per visit</b></p> <p><b>Out-of-Network</b><br/><b>\$0 or 30% of the total cost, depending on your MO HealthNet (Missouri Medicaid) eligibility category, per visit.</b></p>                                                                                                                                                                                                                                                                                                           |

|                                                                                                                                                                                                                                                                         | 2026<br>(this year)                                                                                                                                                                                                                                                         | 2027<br>(next year)                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Specialist office visits</b>                                                                                                                                                                                                                                         | <b>In-Network</b><br>\$0 copay per visit<br><b>Out-of-Network</b><br>\$0 or 30% of the total cost, depending on your MO HealthNet (Missouri Medicaid) eligibility category, per visit.                                                                                      | <b>In-Network</b><br>\$0 copay per visit<br><b>Out-of-Network</b><br>\$0 or 30% of the total cost, depending on your MO HealthNet (Missouri Medicaid) eligibility category, per visit.                                                                                             |
| <b>Inpatient hospital stays</b><br>Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged. | For covered admissions, per admission:<br><br><b>In-Network:</b><br>\$0 copay for each covered hospital stay<br><br><b>Out-of-Network:</b><br>\$0 or \$1,840 copay, depending on your MO HealthNet (Missouri Medicaid) eligibility category, for each covered hospital stay | <b>For covered admissions, per admission:</b><br><br><b>In-Network:</b><br>\$0 copay for each covered hospital stay<br><br><b>Out-of-Network:</b><br>\$0 or \$1,840 copay, depending on your MO HealthNet (Missouri Medicaid) eligibility category, for each covered hospital stay |

|                                                                                                                                                  | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | <p>Part D drug coverage deductible</p> <p>\$515 except for covered insulin products and most adult Part D vaccines</p> <p>If you receive Extra Help, you pay the following amount:<br/>Deductible: \$0</p> <p>Depending on your level of “Extra Help”, you only have to pay the following cost-sharing amounts for your prescription drugs:</p> <p>For generic drugs (including brand drugs treated as generic):</p> <ul style="list-style-type: none"> <li>• \$0 copay or</li> <li>• \$1.60 copay or</li> <li>• \$5.10 copay or</li> </ul> <p>For all other covered drugs:</p> <ul style="list-style-type: none"> <li>• \$0 copay or</li> <li>• \$4.90 copay or</li> <li>• \$12.65 copay</li> </ul> <p>If you don’t get Extra Help, you pay the cost shares below:</p> | <p><b>Part D drug coverage deductible</b></p> <p><b>\$700 except for covered insulin products and most adult Part D vaccines</b></p> <p><b>If you receive Extra Help, you pay the following amount:<br/>Deductible: \$0</b></p> <p><b>Depending on your level of “Extra Help”, you only have to pay the following cost-sharing amounts for your prescription drugs:</b></p> <p><b>For generic drugs (including brand drugs treated as generic):</b></p> <ul style="list-style-type: none"> <li>• <b>\$0 copay or</b></li> <li>• <b>\$1.65 copay or</b></li> <li>• <b>\$5.80 copay or</b></li> </ul> <p><b>For all other covered drugs:</b></p> <ul style="list-style-type: none"> <li>• <b>\$0 copay or</b></li> <li>• <b>\$5.00 copay or</b></li> <li>• <b>\$14.40 copay</b></li> </ul> <p><b>If you don’t get Extra Help, you pay the cost shares below:</b></p> |

|  | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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|  | <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <p>Drug Tier 1:</p> <p>Standard cost sharing:<br/>\$19 copay for a one-month (30-day) supply.</p> <p>Preferred cost sharing:<br/>\$18 copay for a one-month (30-day) supply.</p> <p>Drug Tier 2:</p> <p>Standard cost sharing:<br/>\$20 copay for a one-month (30-day) supply.</p> <p>Preferred cost sharing:<br/>\$19 copay for a one-month (30-day) supply.</p> <p>Drug Tier 3:</p> <p>Standard cost sharing:<br/>20% of the total cost for a one-month (30-day) supply.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Preferred cost sharing:</p> | <p><b>Copayment/Coinsurance during the Initial Coverage Stage:</b></p> <p><b>Drug Tier 1:</b></p> <p><b>Standard cost sharing:</b><br/><b>\$15 copay for a one-month (30-day) supply.</b></p> <p><b>Preferred cost sharing:</b><br/><b>\$0 copay for a one-month (30-day) supply.</b></p> <p><b>Drug Tier 2:</b></p> <p><b>Standard cost sharing:</b><br/><b>25% of the total cost for a one-month (30-day) supply.</b></p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Preferred cost sharing:</b><br/><b>25% of the total cost for a one-month (30-day) supply.</b></p> <p><b>You pay no more than \$35 per month supply of each covered</b></p> |

## Annual Notice of Change for 2027

|  | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>20% of the total cost for a one-month (30-day) supply.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4:</p> <p>Standard cost sharing:<br/>\$100 copay for a one-month (30-day) supply.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Preferred cost sharing:<br/>\$100 copay for a one-month (30-day) supply.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5:</p> <p>Standard cost sharing:<br/>25% of the total cost for a one-month (30-day) supply.</p> <p>Preferred cost sharing:<br/>25% of the total cost for a one-month (30-day) supply.</p> <p>Drug Tier 6:</p> <p>Standard cost sharing:</p> | <p><b>insulin product on this tier.</b></p> <p><b>Drug Tier 3:</b></p> <p><b>Standard cost sharing:</b><br/><b>29% of the total cost for a one-month (30-day) supply.</b></p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Preferred cost sharing:</b><br/><b>29% of the total cost for a one-month (30-day) supply.</b></p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 4:</b></p> <p><b>Standard cost sharing:</b><br/><b>25% of the total cost for a one-month (30-day) supply.</b></p> <p><b>Preferred cost sharing:</b><br/><b>25% of the total cost for a one-month (30-day) supply.</b></p> <p><b>Drug Tier 5:</b></p> |

|  | 2026<br>(this year)                                                                                                                                                                                                                                  | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>\$0 copay for a one-month (30-day) supply.</p> <p>Preferred cost sharing:<br/>\$0 copay for a one-month (30-day) supply.</p> <p>Catastrophic Coverage Stage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs.</p> | <p><b>Standard cost sharing:</b><br/><b>25% of the total cost for a one-month (30-day) supply.</b></p> <p><b>Preferred cost sharing:</b><br/><b>25% of the total cost for a one-month (30-day) supply.</b></p> <p><b>Drug Tier 6:</b></p> <p><b>Standard cost sharing:</b><br/><b>\$0 copay for a one-month (30-day) supply.</b></p> <p><b>Preferred cost sharing:</b><br/><b>\$0 copay for a one-month (30-day) supply.</b></p> <p><b>Catastrophic Coverage Stage:</b></p> <p><b>During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.</b></p> |

**SECTION 1            Changes to Benefits & Costs for Next Year**

**Section 1.1   Changes to the Monthly Plan Premium**

|                                                                                                                                                                                                                                      | 2026<br>(this year) | 2027<br>(next year) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| <b>Monthly plan premium</b><br>(You must also continue to pay your Medicare Part B premium unless it's paid for you by MO HealthNet (Missouri Medicaid).)<br><br>Because you get Extra Help, you do not pay a premium for this plan. | \$0                 | \$0                 |

**Section 1.2   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've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2026<br>(this year) | 2027<br>(next year)                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>In-network maximum out-of-pocket amount</b></p> <p>Cost-sharing paid by the beneficiary, MO HealthNet (Missouri Medicaid), and other secondary insurance contributes towards this out-of-pocket maximum. Because our members get most cost sharing paid by MO HealthNet (Missouri 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.</p> <p>Your costs for covered medical services (such as copayments and deductibles) from network providers <b>count</b> toward your in-network maximum out-of-pocket amount.</p> <p>Your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount.</p> | \$9,250             | <p><b>\$9,850</b></p> <p><b>Once you've paid \$9,850 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.</b></p> |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2026<br>(this year) | 2027<br>(next year)                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Combined maximum out-of-pocket amount</b></p> <p>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 received in-network. However, depending on your Medicaid eligibility category, out-of-network providers that are not enrolled in your state Medicaid may charge out-of-pocket cost-sharing that would apply to your maximum out-of-pocket.</p> <p>Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers <b>count</b> toward your combined maximum out-of-pocket amount.</p> <p>Your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount.</p> | \$13,900            | <p><b>\$14,800</b></p> <p><b>Once you've paid \$14,800 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.</b></p> |

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider & Pharmacy Directory* [go.wellcare.com/2027providerdirectories](https://go.wellcare.com/2027providerdirectories) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here’s how to get an updated *Provider & Pharmacy Directory*:

- Visit our website at [go.wellcare.com/2027providerdirectories](https://go.wellcare.com/2027providerdirectories).
- Call Member Services at 1-833-444-9089 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider & Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-833-444-9089 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your Evidence of Coverage.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2027 *Provider & Pharmacy Directory* [go.wellcare.com/2027providerdirectories](https://go.wellcare.com/2027providerdirectories) to see which pharmacies are in our network. Here’s how to get an updated *Provider & Pharmacy Directory*:

- Visit our website at [go.wellcare.com/2027providerdirectories](https://go.wellcare.com/2027providerdirectories).
- Call Member Services at 1-833-444-9089 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider & Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-833-444-9089 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

|                      | 2026<br>(this year)                                                                                                                                                                                                        | 2027<br>(next year)                                                                                                      |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Prior Authorizations | <div>The following in-network benefits have a change in prior authorization requirements.<ul style="list-style-type: none"><li>• Additional Telehealth Benefits do <u>not</u> require prior authorization.</li></ul></div> | <ul style="list-style-type: none"><li>• <b>Additional Telehealth Benefits may require prior authorization.</b></li></ul> |

|                                                                                                                   | <b>2026<br/>(this year)</b>                                                                                                                                                                                                                                                                                      | <b>2027<br/>(next year)</b>                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Routine dental services -<br/>Comprehensive dental services</b>                                                | Up to a \$5,000 allowance for all in-network and out-of-network covered comprehensive dental services every year.                                                                                                                                                                                                | <b>Up to a \$3,000 allowance for all in-network and out-of-network covered comprehensive dental services every year.</b>                                                          |
| <b>Routine dental services -<br/>Diagnostic and preventive dental services - Other diagnostic dental services</b> | Limited to 1 other diagnostic service(s) every date of service to 3 plan years depending on type of service.                                                                                                                                                                                                     | <b>Limited to 1 other diagnostic service(s) per visit.</b>                                                                                                                        |
| <b>Routine dental services -<br/>Comprehensive dental services -<br/>Periodontics</b>                             | 1 scaling and root planing per quadrant every 24 months.<br>1 removal of non-resorbable barrier per quadrant or site per consecutive 36 months.<br>8 antimicrobial site applications every 24 months billed at least 28 days after scaling and root planing.<br>Other periodontic services every 6 to 36 months. | <b>1 scaling and root planing per quadrant every 2 plan years. 2 periodontal maintenance visits per year. Other periodontal services every 2 plan years to once per lifetime.</b> |
| <b>Routine dental services -<br/>Comprehensive dental services -<br/>Prosthodontics (fixed)</b>                   | Limited to 1 prosthodontic (fixed) service(s) every date of service to 7 plan years per tooth depending on type of service.                                                                                                                                                                                      | <b>Limited to 1 prosthodontic (fixed) services(s) every 2 to 7 years per tooth depending on type of service.</b>                                                                  |

|                                                                                                                   | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Routine dental services -<br/>Comprehensive dental services -<br/>Prosthodontics (removable)</b>               | Limited to 1 prosthodontic, removable service(s) every date of service to 5 years depending on type of service.                                                                                                                                                                                                                                                                                                                                               | <b>Limited to 1 prosthodontic, removable service(s) every year to 5 years depending on type of service.</b>                                                                                                                                                                                                                                                                                        |
| <b>Routine dental services -<br/>Diagnostic and preventive dental services - Other preventive dental services</b> | Limited to 1 other preventive dental service(s) every date of service to 3 plan years depending on type of service.                                                                                                                                                                                                                                                                                                                                           | <b>Limited to 1 other preventive dental services(s) per tooth per 6 months.</b>                                                                                                                                                                                                                                                                                                                    |
| <b>Fitness benefit</b>                                                                                            | <p>You pay a \$0 copay for the fitness benefit.</p> <p>The fitness benefit offers access to participating fitness centers, provides digital resources through virtual classes, on-demand videos and a mobile app. For members who do not live near a participating fitness center or prefer to exercise at home, can choose from available at home kits to be shipped to them at no cost. A wearable fitness tracker is included as one of those choices.</p> | <p><b>You pay a \$0 copay for the fitness benefit.</b></p> <p><b>The fitness benefit offers access to participating fitness centers, provides digital resources through virtual classes, on-demand videos and a mobile app. For members who do not live near a participating fitness center or prefer to exercise at home, can choose a home fitness kit to be shipped to them at no cost.</b></p> |
| <b>Hearing services - Hearing aids</b>                                                                            | Limited to 2 hearing aid(s) every year, including a 2-year supply of batteries.                                                                                                                                                                                                                                                                                                                                                                               | <b>Limited to 2 hearing aid(s) every year, including a supply of batteries.</b>                                                                                                                                                                                                                                                                                                                    |

|                                                              | 2026<br>(this year)                                                                                                                                                                                     | 2027<br>(next year)                                              |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| <b>Meals - Chronic (limitations and exclusions apply)</b>    | You pay a \$0 copay for chronic meals.<br>There is a maximum of 3 meals per day for up to 28 days, for a total of 84 meals per month. The benefit may be received for up to 3 months.                   | <b>Meals - chronic is <u>not</u> covered.</b>                    |
| <b>Meals - Post-acute (limitations and exclusions apply)</b> | You pay a \$0 copay for post-acute meals.<br>There is a maximum of 3 meals per day for 14 days for a total of 42 meals. Service must be requested within 45 days of discharge from your inpatient stay. | <b>Meals - post-acute is <u>not</u> covered.</b>                 |
| <b>Personal Emergency Response System (Medical Alert)</b>    | You pay a \$0 copay. Limited to one personal emergency medical response device per lifetime and the monthly fee.                                                                                        | <b>Personal Emergency Response System is <u>not</u> covered.</b> |

|                                                                                              | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                           | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Skilled nursing facility (SNF) care</b>                                                   | <p>For Medicare-covered admission per benefit period:</p> <p><b>Out-of-Network</b></p> <p>You pay \$0 copay per day, for days 1 to 20, \$0 or \$218 copay, depending on your MO HealthNet (Missouri Medicaid) eligibility category, per day, for days 21 to 70, and a \$0 copay per day, for days 71 to 100 for Medicare-covered skilled nursing facility care.</p> <p>Beyond day 100: You are responsible for all costs.</p> | <p><b>For Medicare-covered admission per benefit period:</b></p> <p><b>Out-of-Network</b></p> <p><b>You pay \$0 copay per day, for days 1 to 20, \$0 or \$221 copay, depending on your MO HealthNet (Missouri Medicaid) eligibility category, per day, for days 21 to 70, and a \$0 copay per day, for days 71 to 100 for Medicare-covered skilled nursing facility care.</b></p> <p><b>Beyond day 100: You are responsible for all costs.</b></p> |
| <b>Special Supplemental Benefits for the Chronically Ill (SSBCI) - Qualifying Conditions</b> | <p>The following are <u>not</u> qualified conditions:</p> <ul style="list-style-type: none"> <li>Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell</li> <li>Immunodeficiency and Immunosuppressive disorders</li> </ul> <p>Please see your Evidence of Coverage for more information.</p>                                                                                                    | <p><b>The following are qualified conditions:</b></p> <ul style="list-style-type: none"> <li><b>Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell</b></li> <li><b>Immunodeficiency and Immunosuppressive disorders</b></li> </ul> <p><b>Please see your Evidence of Coverage for more information.</b></p>                                                                                                        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Special Supplemental Benefits for the Chronically Ill (SSBCI)</b></p> <p>Benefits mentioned are a part of Special Supplemental Benefits for the Chronically Ill. Not all members will qualify. In addition to being high-risk, you must have one or more of the following chronic conditions: cancer, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, diabetes. There are other eligible conditions not listed. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us or see the plan's Evidence of Coverage.</p> | <p>The benefits shown below are available as part of SSBCI, if you are determined eligible. You pay a \$0 copay. You may use your Wellcare Spendables® allowance on these benefits:</p> <ul style="list-style-type: none"> <li>• Gas pay-at-pump</li> <li>• Healthy Food</li> <li>• Home Assistance and Safety Items and Services</li> <li>• Pest Control Items and Services</li> <li>• Rent Assistance</li> <li>• Utility Assistance</li> </ul> <p>The following benefits are <u>not</u> covered:</p> <ul style="list-style-type: none"> <li>• Personal Care Items</li> <li>• Robotic Companion Pets</li> </ul> <p>Please see your Evidence of Coverage for more information.</p> | <p><b>The benefits shown below are available as part of SSBCI, if you are determined eligible.</b></p> <p><b>You pay a \$0 copay. You may use your Wellcare Spendables® allowance on these benefits:</b></p> <ul style="list-style-type: none"> <li>• <b>Gas pay-at-pump</b></li> <li>• <b>Healthy Food</b></li> <li>• <b>Personal Care Items</b></li> <li>• <b>Pest Control Items</b></li> <li>• <b>Rent Assistance</b></li> <li>• <b>Robotic Companion Pets</b></li> <li>• <b>Utility Assistance</b></li> </ul> <p><b>The following benefits are <u>not</u> covered:</b></p> <ul style="list-style-type: none"> <li>• <b>Home Assistance and Safety Items and Services</b></li> <li>• <b>Pest Control Services</b></li> </ul> <p><b>Please see your Evidence of Coverage for more information.</b></p> |

|                                | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2027<br>(next year)                                                                                    |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <b>Transportation services</b> | <p><b>In-Network</b></p> <p>You pay a \$0 copay for 36 non-emergency trips within our service area every year for in-network and out-of-network combined.</p> <p>Rides (also called “trips”) are limited to 100 miles one-way. For routine care, call up to 1 month and at least 3 days in advance. Same day rides are subject to availability. A trip is considered one-way transportation by taxi, passenger car, wheelchair van or rideshare services to a healthcare location.</p>               | <p><b>In-Network</b></p> <p><b>Non-emergency medical transportation is <u>not</u> covered.</b></p>     |
| <b>Transportation services</b> | <p><b>Out-of-Network</b></p> <p>You pay 75% of the total cost for 36 non-emergency trips within our service area every year for in-network and out-of-network combined.</p> <p>Rides (also called “trips”) are limited to 100 miles one-way. For routine care, call up to 1 month and at least 3 days in advance. Same day rides are subject to availability. A trip is considered one-way transportation by taxi, passenger car, wheelchair van or rideshare services to a healthcare location.</p> | <p><b>Out-of-Network</b></p> <p><b>Non-emergency medical transportation is <u>not</u> covered.</b></p> |

|                      | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                    | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Wellcare Spendables® | <p>You pay a \$0 copay. You receive a \$130 monthly allowance.</p> <p>Your allowance can be used toward:</p> <ul style="list-style-type: none"><li>• Dental, vision, and hearing</li><li>• Over-the-counter items (OTC)</li><li>• SSBCI benefits (for members who qualify)</li></ul> <p>Please see your Evidence of Coverage for more information.</p> | <p><b>You pay a \$0 copay. You receive a \$43 monthly allowance.</b></p> <p><b>Your allowance can be used toward:</b></p> <ul style="list-style-type: none"><li>• <b>Dental, vision, and hearing</b></li><li>• <b>Over-the-counter items (OTC)</b></li><li>• <b>SSBCI benefits (for members who qualify)</b></li></ul> <p><b>Please see your Evidence of Coverage for more information.</b></p> |

Section 1.6 Changes to Part D 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 calendar 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’re taking, we’ll send you a notice about the change.

If you’re affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-833-444-9089 (TTY users call 711) for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30th, 2026, call Member Services at 1-833-444-9089 (TTY users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 2 (Preferred Brand), Tier 3 (Non-Preferred Drug), Tier 4 (Injectable Drugs), and Tier 5 (Specialty Tier) drugs until you reach the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach \$2,400.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You also pay nothing for excluded drugs that are covered under our enhanced benefit. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

|                   | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Yearly Deductible | <p>If you qualify for Extra Help from Medicare:<br/>\$0</p> <p>If you don't qualify for Extra Help from Medicare:<br/>\$515</p> <p>During this stage, you pay \$19 <i>standard cost sharing</i> or \$18 <i>preferred cost sharing</i> for drugs on Tier 1: Preferred Generic and \$0 <i>cost sharing</i> for drugs on Tier 6: Select Care Drugs and the full cost of drugs on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you've reached the yearly deductible.</p> | <p><b>If you qualify for Extra Help from Medicare:<br/>\$0</b></p> <p><b>If you don't qualify for Extra Help from Medicare:<br/>\$700</b></p> <p><b>During this stage, you pay \$15 <i>standard cost sharing</i> or \$0 <i>preferred cost sharing</i> for drugs on Tier 1: Generic and \$0 <i>cost sharing</i> for drugs on Tier 6: Select Care Drugs and the full cost of drugs on Tier 2: Preferred Brand, Tier 3: Non-Preferred Drug, Tier 4: Injectable Drugs, and Tier 5: Specialty Tier until you've reached the yearly deductible.</b></p> |

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 2 (Preferred Brand) and Tier 4 (Injectable Drugs), your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2026 to 2027.

The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard and preferred cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you’ve paid \$2,400 out of pocket for covered Part D drugs, you’ll move to the next stage (the Catastrophic Coverage Stage).

|                                                                                             | 2026<br>(this year)                                                                                                                                                                                                                                                                                                              | 2027<br>(next year)                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you do qualify for Extra Help from Medicare to help pay for your prescription drug costs |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                  |
| For generic drugs (including brand drugs treated as generic)                                | <p>Depending on your level of “Extra Help”, you only have to pay the following cost-sharing amounts for your prescription drugs:</p> <ul style="list-style-type: none"><li>• \$0 copay or</li><li>• \$1.60 copay or</li><li>• \$5.10 copay</li></ul> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p>  | <p>Depending on your level of “Extra Help”, you only have to pay the following cost-sharing amounts for your prescription drugs:</p> <ul style="list-style-type: none"><li>• \$0 copay or</li><li>• \$1.65 copay or</li><li>• \$5.80 copay</li></ul> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p>  |
| For all other covered drugs:                                                                | <p>Depending on your level of “Extra Help”, you only have to pay the following cost-sharing amounts for your prescription drugs:</p> <ul style="list-style-type: none"><li>• \$0 copay or</li><li>• \$4.90 copay or</li><li>• \$12.65 copay</li></ul> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> | <p>Depending on your level of “Extra Help”, you only have to pay the following cost-sharing amounts for your prescription drugs:</p> <ul style="list-style-type: none"><li>• \$0 copay or</li><li>• \$5.00 copay or</li><li>• \$14.40 copay</li></ul> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> |

If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs

|                                                                                      | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                  | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>2026: Drug Tier 1 - Preferred Generic:</b><br><b>2027: Drug Tier 1 - Generic:</b> | <p><i>Standard cost sharing:</i> You pay a \$19 copay</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> <p><i>Preferred cost sharing:</i> You pay a \$18 copay</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p>                                                                                                                           | <p><b><i>Standard cost sharing:</i> You pay a \$15 copay</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> <p><b><i>Preferred cost sharing:</i> You pay a \$0 copay</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p>                                                                                                                                                                                                                                  |
| <b>2026: Drug Tier 2 - Generic:</b><br><b>2027: Drug Tier 2 - Preferred Brand:</b>   | <p><i>Standard cost sharing:</i> You pay a \$20 copay</p> <p>Insulin products are <u>not</u> covered on this tier.</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> <p><i>Preferred cost sharing:</i> You pay a \$19 copay</p> <p>Insulin products are <u>not</u> covered on this tier.</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> | <p><b><i>Standard cost sharing:</i> You pay 25% of the total cost</b></p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> <p><b><i>Preferred cost sharing:</i> You pay 25% of the total cost</b></p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> |

|                                                                                               | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>2026: Drug Tier 3 - Preferred Brand:</b><br><b>2027: Drug Tier 3 - Non-Preferred Drug:</b> | <p><i>Standard cost sharing:</i> You pay 20% of the total cost</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> <p><i>Preferred cost sharing:</i> You pay 20% of the total cost</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> | <p><b><i>Standard cost sharing:</i> You pay 29% of the total cost</b></p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> <p><b><i>Preferred cost sharing:</i> You pay 29% of the total cost</b></p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> |

|                                                                                                | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>2026: Drug Tier 4 - Non-Preferred Drug:</b><br><b>2027: Drug Tier 4 - Injectable Drugs:</b> | <p><i>Standard cost sharing:</i> You pay a \$100 copay.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> <p><i>Preferred cost sharing:</i> You pay a \$100 copay</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> | <p><b><i>Standard cost sharing:</i> You pay 25% of the total cost</b></p> <p><b>Insulin products are <u>not</u> covered on this tier.</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> <p><b><i>Preferred cost sharing:</i> You pay 25% of the total cost</b></p> <p><b>Insulin products are <u>not</u> covered on this tier.</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> |
| <b>Drug Tier 5 - Specialty Tier:</b>                                                           | <p><i>Standard cost sharing:</i> You pay 25% of the total cost</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p> <p><i>Preferred cost sharing:</i> You pay 25% of the total cost</p> <p>A one-month (30-day) mail-order prescription is <u>not</u> covered.</p>                                                                                                                                                                                  | <p><b><i>Standard cost sharing:</i> You pay 25% of the total cost</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p> <p><b><i>Preferred cost sharing:</i> You pay 25% of the total cost</b></p> <p><b>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b></p>                                                                                                                                         |

|                                         | 2026<br>(this year)                                                                                                                                                                                                                                       | 2027<br>(next year)                                                                                                                                                                                                                                                  |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Drug Tier 6 - Select Care Drugs:</b> | <i>Standard cost sharing:</i> You pay a \$0 copay<br>A one-month (30-day) mail-order prescription is <u>not</u> covered.<br><br><i>Preferred cost sharing:</i> You pay a \$0 copay<br>A one-month (30-day) mail-order prescription is <u>not</u> covered. | <b><i>Standard cost sharing:</i> You pay a \$0 copay<br/>A one-month (30-day) mail-order prescription is <u>not</u> covered.<br/><br/><i>Preferred cost sharing:</i> You pay a \$0 copay<br/>A one-month (30-day) mail-order prescription is <u>not</u> covered.</b> |

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.

**SECTION 2      Administrative Changes**

The information in the Administrative Changes grid below reflects year-over-year changes to your plan that do not directly impact benefits or cost-shares.

|                                                                              | 2026 (this year)                                                                                         | 2027 (next year)                                                                                                                             |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Covered supplemental benefits you receive from our network providers.</b> | Services are provided through our current network of vendors.                                            | <b>Our vendor network may change in 2027. Review the 2027 Provider &amp; Pharmacy Directory to see if your providers are in our network.</b> |
| <b>Wellcare Spendables®</b>                                                  | Items purchased in store or online may be returned following the retailers return and exchange policies. | <b>Items purchased online are final sale. If item is damaged or spoiled, please contact us.</b>                                              |

## SECTION 3      How to Change Plans

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**To stay in Wellcare Home State Health Dual Access Open (PPO D-SNP), you don't need to do anything.** Unless you sign up for a different Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Wellcare Home State Health Dual Access Open (PPO D-SNP).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Wellcare Home State Health Dual Access Open (PPO D-SNP). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from Wellcare Home State Health Dual Access Open (PPO D-SNP).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll or visit our website to disenroll online at [go.wellcare.com/Medicare](https://go.wellcare.com/Medicare). Call Member Services at 1-833-444-9089 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048.
- **To learn more about Original Medicare and the different types of Medicare plans,** visit [Medicare.gov](https://www.Medicare.gov), check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).

### Section 3.1    Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

### Section 3.2    Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have MO HealthNet (Missouri Medicaid)

- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have MO HealthNet (Missouri Medicaid), you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- 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 MO HealthNet (Missouri Medicaid) benefits and services in one plan.

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

## SECTION 4      Get Help Paying for Prescription Drugs

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You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778.
  - Your State MO HealthNet (Missouri Medicaid) office.
- **Help from your state's pharmaceutical assistance program (SPAP).** Missouri has a program called Missouri Rx Plan (MORx) that helps people pay for prescription drugs based on their

financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [shiphelp.org](http://shiphelp.org), or call 1-800-MEDICARE.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Missouri AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call the Missouri AIDS Drug Assistance Program (ADAP), at 1-888-252-8045 (TTY 711) from 8:00 a.m. - 5:00 p.m. local time, Monday - Friday. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-833-750-9969 (TTY users call 1-800-716-3231) or visit [Medicare.gov](http://Medicare.gov).

## SECTION 5      Questions?

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### Get Help from Wellcare Home State Health Dual Access Open (PPO D-SNP)

- **Call Member Services at 1-833-444-9089. (TTY users call 711.)**

We're available for phone calls. 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. Calls to these numbers are free.

- **Read your 2027 Evidence of Coverage**

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for Wellcare Home State Health Dual Access Open (PPO D-SNP). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at [go.wellcare.com/Medicare](https://go.wellcare.com/Medicare) or call Member Services at 1-833-444-9089 (TTY users call 711) to ask us to mail you a copy.

- **Visit** [go.wellcare.com/Medicare](https://go.wellcare.com/Medicare)

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).

## Get Free Counseling about Medicare

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

Call Missouri State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. They can help you understand your Medicare and MO HealthNet (Missouri Medicaid) plan choices and answer questions about switching plans. Call Missouri State Health Insurance Assistance Program (SHIP) at 1-800-390-3330. Learn more about Missouri State Health Insurance Assistance Program (SHIP) by visiting (<https://www.missouriship.org/>).

## Get Help 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 can call 1-877-486-2048.

- **Chat live with [Medicare.gov](https://www.medicare.gov)**

You can chat live at [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit [Medicare.gov](https://www.medicare.gov)**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2027***

The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

### **Get Help from MO HealthNet (Missouri Medicaid)**

Call MO HealthNet (Missouri Medicaid) at 1-573-751-3425 from 8:00 a.m. - 5:00 p.m. CT, Monday - Friday. TTY users call 711 for help with MO HealthNet (Missouri Medicaid) enrollment or benefit questions.