Wellcare Superior HealthPlan Dual Align (HMO D-SNP) offered by Superior HealthPlan, Inc.

Annual Notice of Change for 2027

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, rules and costs. This *Annual Notice of Change* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at go.wellcare.com/TX. Call Member Services at the number at the bottom of the page to get a copy by mail. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Additional resources

- This document is available for free in Spanish.
- You can get this Annual Notice of Change for free in other formats, such as large print, braille, or audio. Call 1-855-445-3556 (TTY 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. If you leave a voicemail message, please include your name, and telephone number and a team member will return your call within one (1) business day. The call is free.
- We can send materials to you in a language other than English (in addition to the language listed above) or in an alternate format if you ask for it this way. This is called a "standing request". We will document your choice.

OMB Approval 0938-1444 (Expires: 5/31/2029)

- To make a standing request, change a standing request or make a one-time request, please call Member Services at the phone number on the bottom of this page. 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.

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A. Disclaimers

- 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.
- Based on a Model of Care review, Wellcare Superior HealthPlan Dual Align (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) through 2028.
- As a Wellcare Superior HealthPlan Dual Align (HMO D-SNP) member, you have coverage for both Medicare and Medicaid. You will receive your Medicare benefits and your STAR+PLUS Medicaid benefits through Wellcare Superior HealthPlan Dual Align (HMO D-SNP). You can learn more about providers who participate in Wellcare Superior HealthPlan Dual Align (HMO D-SNP) for Medicare and Medicaid by visiting https://www.wellcarefindaprovider.com/navigate-a-network.html. To request written copies of our Medicare and Medicaid Provider Directories, please contact us at 1-855-445-3556 (TTY: 711).
- Wellcare (HMO and HMO SNP) includes products that are underwritten by WellCare of Texas, Inc., Superior HealthPlan, Inc., and SelectCare of Texas, Inc.

B. Reviewing your Medicare and STAR+PLUS (Medicaid) coverage for next year

It's important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section D** for more information on changes to your benefits for next year.

If you choose to leave our plan, your Medicare membership will end on the last day of the month in which your request was made. Your STAR+PLUS benefits may remain with our Wellcare Superior HealthPlan Dual Align (HMO D-SNP) for one additional month, until your new STAR+PLUS health plan is active. There will be no gap in your STAR+PLUS coverage. You'll still be in the Medicare and STAR+PLUS programs as long as you're eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section F2.**
- STAR+PLUS options and services in **Section F2**.

B1. Information about Wellcare Superior HealthPlan Dual Align (HMO D-SNP)

- Wellcare Superior HealthPlan Dual Align (HMO D-SNP) is a health plan that contracts with both Medicare and STAR+PLUS to provide benefits of both programs to members.
- When this *Annual Notice of Change* says "we," "us," "our," or "our plan," it means Wellcare Superior HealthPlan Dual Align (HMO D-SNP).

B2. Important things to do

- **Check if there are any changes to our benefits that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they'll work for you next year.
  - Refer to **Section D1** for information about benefit changes for our plan.
- **Check if there are any changes to our drug coverage that may affect you.**
  - Will your drugs be covered? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy or quantity limits?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section D2** for information about changes to our drug coverage.
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section C** for information about our *Provider and Pharmacy Directory*.

- **Think about your overall costs in the plan.**
  - How much will you spend out-of-pocket for the services and drugs you use regularly?
  - How do the total costs compare to other coverage options?
- **Think about if you're happy with our plan.**

If you decide to stay with Wellcare Superior HealthPlan Dual Align (HMO D-SNP):	**If you decide to change plans:**
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in Wellcare Superior HealthPlan Dual Align (HMO D-SNP) for both your Medicare and STAR+PLUS coverage.	If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section F2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month. If you move to another Medicare plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan, your STAR+PLUS plan will automatically change to match that choice. If you choose to move to Original Medicare, then your STAR+PLUS plan will remain the same.

C. Changes to our network providers and pharmacies

Our provider and pharmacy networks have changed for 2027.

Please review the 2027 *Provider and Pharmacy Directory* to find out if your providers (primary care providers, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at go.wellcare.com/2027providerdirectories. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory.*

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook* or call Member Services at the number at the bottom of the page for help.

D. Changes to benefits and costs for next year

D1. Changes to benefits for medical services

We're changing our coverage for certain medical services next year. The table below describes these changes.

	2026 (this year)	2027 (next year)
Prior Authorizations	The following in-network benefits have a change in prior authorization requirements.	
	Prior authorization **isn't** required for services listed below: Medicare-covered telehealth benefits	Prior authorization may be required for services listed below: Medicare-covered telehealth benefits
Referrals **(This section is continued on the next page)**	The following in-network benefits have a change in referral requirements.	

	2026 (this year)	2027 (next year)
Referrals (continued)	Certain Medicare-covered services* do not require a referral. Chiropractic care – Routine services does not require a referral. Podiatry – Routine services does not require a referral.	Certain Medicare-covered services* may require a referral. Chiropractic care – Routine services may require a referral. Podiatry – Routine services may require a referral.
Dental services – Routine dental care **(This section is continued on the next page)**	Our plan covers routine dental care under the Medicare coverage. You pay a **$0** copay for the following: **Preventive services:** Oral exam* Dental X-rays* Other diagnostic dental services – 1 every date of service to 3 plan years depending on type of service Cleaning* Fluoride treatment* Other preventive dental services – 1 every date of service to 3 plan years depending on type of service **Comprehensive services (limited to $5,000 allowance every year):** Restorative services* Endodontics* Periodontics – 1 every 6 months to 3 plan years	Our plan covers routine dental care under the Medicare coverage. You pay a **$0** copay for the following: **Preventive services:** Oral exam* Dental X-rays* Other diagnostic dental services – 1 per visit Cleaning* Fluoride treatment* Other preventive dental services – 1 per tooth per 6 months **Comprehensive services (limited to $5,000 allowance every year):** Restorative services* Endodontics* Periodontics – 1 every 6 months to per lifetime

	2026 (this year)	2027 (next year)
Dental services – Routine dental care (continued)	depending on the type of service Prosthodontics, removable* Prosthodontics, fixed – 1 every date of service to 7 plan years per tooth depending on type of service Oral/maxillofacial surgery* Adjunctive general services* *Benefit frequency limits vary based on services you receive. Refer to the *Member Handbook* for more details	Prosthodontics, removable* Prosthodontics, fixed – 1 every 2 to 7 years per tooth depending on type of service Oral/maxillofacial surgery* Adjunctive general services* *Benefit frequency limits vary based on services you receive. Refer to the *Member Handbook* for more details.
Meals - Post-acute (limitations and exclusions apply)	You pay a **$0** copay for post-acute meals. 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.	You pay a **$0** copay for post-acute meals. There is a maximum of 2 meals per day for 14 days for a total of 28 meals. Service must be requested within 45 days of discharge from your inpatient stay.
Personal Emergency Response System (Medical Alert)	You pay a **$0** copay. Limited to one personal emergency medical response device per lifetime and the monthly fee.	You pay a **$0** copay. Limited to one personal emergency medical response device and monitoring services. Included with the PERS benefit is an app that provides access to you and your family, or emergency contacts for real-time activity and alerts.

	2026 (this year)	2027 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI) – Qualifying Conditions (This section is continued on the next page) **Special Supplemental Benefits for the Chronically Ill (SSBCI) – Qualifying Conditions (continued)**	The following **aren't** qualified conditions: • Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell • Immunodeficiency and Immunosuppressive disorders Please see your *Member Handbook* for more information.	The following are qualified conditions: • Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell • Immunodeficiency and Immunosuppressive disorders Please see your *Member Handbook* for more information.
Special Supplemental Benefits for the Chronically Ill (SSBCI) 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	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: • Gas pay-at-pump • Healthy Food • Home Assistance and Safety Items and Services • Pest Control Items and Services • Rent Assistance • Utility Assistance The following benefits **aren't** covered: • Personal Care Items • Robotic Companion Pets	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: • Gas pay-at-pump • Healthy Food • Personal Care Items • Pest Control Items • Rent Assistance • Robotic Companion Pets • Utility Assistance The following benefits **aren't** covered: • Home Assistance and Safety Items and Services • Pest Control Services

	2026 (this year)	2027 (next year)
contact us or see the plan's *Member Handbook*.	Please see your *Member Handbook* for more information.	Please see your *Member Handbook* for more information.
Wellcare Spendables®	You pay a **$0** copay. You receive a $177 monthly allowance. Your allowance can be used toward: • Dental, vision, and hearing • Over-the-counter items (OTC) • SSBCI benefits (for members who qualify) Please see your *Member Handbook* for more information.	You pay a **$0** copay. You receive a $172 monthly allowance. Your allowance can be used toward: • Over-the-counter items (OTC) • SSBCI benefits (for members who qualify) Expenses for dental, vision and hearing **aren't** covered under the Wellcare Spendables® benefit. Please see your *Member Handbook* for more information.

* These Medicare-covered services do not need a referral in 2026, but may need a referral in 2027: Inpatient Hospital-Acute; Inpatient Hospital Psychiatric; Skilled Nursing Facility (SNF); Cardiac Rehabilitation Services; Intensive Cardiac Rehabilitation Services; Pulmonary Rehabilitation Services; SET for PAD Services; Partial Hospitalization; Intensive Outpatient Program Services; Home Health Services; Chiropractic Services; Occupational Therapy Services; Physician Specialist Services; Individual Sessions for Mental Health Specialty Services; Group Sessions for Mental Health Specialty Services; Podiatry Services; Other Health Care Professional; Individual Sessions for Psychiatric Services; Group Sessions for Psychiatric Services; Physical Therapy and Speech Language Pathology Therapy Services; Additional Telehealth Services; Opioid Treatment Services; Diagnostic Procedures/Tests; Lab Services; Diagnostic Radiological Services; Therapeutic Radiological Services; Outpatient X-Ray Services; Outpatient Hospital Services; Hospital Observation Services; Ambulatory Surgical

Center (ASC) Services; Individual Sessions for Outpatient Substance Abuse; Group Sessions for Outpatient Substance Abuse; Outpatient Blood Services; Dialysis Services; Kidney Disease Education Services; Glaucoma Screening; Diabetes Self-Management Training; Digital Rectal Exams; EKG following Welcome Visit.

D2. Changes to drug coverage

Changes to our *Drug List*

Our List of Covered Drugs is also called the Formulary or *Drug List*. A copy of our *Drug List* is posted online at go.wellcare.com/druglist-17.

We made changes to our *Drug List*, which could include removing or adding drugs, changing drugs we cover, and changes to the restrictions that apply to our coverage for certain drugs.

Review the *Drug List* to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

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 and/or HHS 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 a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
    - You can call Member Services at the numbers at the bottom of the page or contact your service coordinator to ask for a *List of Covered Drugs* that treat the same condition.
    - This list can help your provider find a covered drug that might work for you.
- Ask us to cover a temporary supply of the drug.
    - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
    - This temporary supply is for up to 30 days at a retail pharmacy and for up to 31 days at a long-term care pharmacy. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your Member Handbook.)
    - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make

an exception for you and cover your current drug. To learn what you must do to ask for an exception, refer to **Chapter 9** of the 2027 *Member Handbook* or call Member Services.

- If you have been in the plan for more than 90 days and live in a long-term care facility, we will cover a one-time 31-day supply, or less if your prescription is written for fewer days. This is in addition to the long-term care transition supply.
- If your level of care changes (such as moving to or from a long-term care facility or hospital), we will cover one temporary 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 30-day supply.
- Some *Drug List* exceptions will still be covered next year. Refer to the approval letter you received. The approval letter includes information about your specific drug approval limits and the date the drug coverage will end. If we decide not to renew your approval, we will send you a new letter at least 60 days prior to the end of the year. This letter will include when the specific drug exception approval will end and how to ask for an exception. To learn what you must do to ask for an exception, refer to **Chapter 9** of the 2026 *Member Handbook* or call Member Services.

If we approved your formulary exception in 2026, your authorization may still be valid. Please refer to your approval letter, which contains the end date of your formulary exception. If you can't find your approval letter or have questions, please call Member Services.

Changes to drug costs

We moved some of the drugs on the *Drug List* to a lower or higher drug tier. To find out if your drugs are in a different tier, look them up in the *Drug List*.

The following table shows your costs for drugs in each of our six drug tiers.

	2026 (this year)	2027 (next year)
Drugs in Tier 1 2026: (Preferred Generic) 2027: (Generic) Cost for a one-month supply of a drug in Tier 1 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply depends on your level of Extra Help. For generic drugs (including brand drugs treated as generic), you pay ○ $0 copay or ○ $1.60 copay or ○ $5.10 copay for a one-month supply <u>For all other covered drugs, you pay:</u> ○ $0 copay or ○ $4.90 copay or ○ $12.65 copay for a one-month supply. Extra Help is a program that helps pay for your drugs. We sent you a separate material, called the Evidence of	Your copay for a one-month (30-day) supply is **$0**.
Drugs in Tier 2 2026: (Generic) 2027: (Preferred Brand) Cost for a one-month supply of a drug in Tier 2 that's filled at a network pharmacy		Your copay for a one-month (30-day) supply is **$0**.
Drugs in Tier 3 2026: (Preferred Brand) 2027: (Non-Preferred Drug) Cost for a one-month supply of a drug in Tier 3 that's filled at a network pharmacy		Your copay for a one-month (30-day) supply is **$0**.

	2026 (this year)	2027 (next year)
Drugs in Tier 4 2026: (Non-Preferred Drug) 2027: (Injectable Drugs) Cost for a one-month supply of a drug in Tier 4 that's filled at a network pharmacy	Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs, which tells about your drug costs.	Your copay for a one-month (30-day) supply is **$0**.
Drugs in Tier 5 2026: (Specialty Tier) 2027: (Specialty Tier) Cost for a one-month supply of a drug in Tier 5 that's filled at a network pharmacy		Your copay for a one-month (30-day) supply is **$0**.
Drugs in Tier 6 2026: (Select Care Drugs) 2027: (Select Care Drugs) Cost for a one-month supply of a drug in Tier 6 that's filled at a network pharmacy		Your copay for a one-month (30-day) supply is **$0**.

E. 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)
Deeming period change	If you are no longer eligible for STAR+PLUS, you may stay enrolled in the plan for **6 months** while you try to regain Medicaid eligibility.	If you are no longer eligible for STAR+PLUS, you may stay enrolled in the plan for **3 months** while you try to regain Medicaid eligibility.
Covered supplemental benefits you receive from our network providers	Services are provided through our current network of vendors.	Our vendor network may change in 2027. Review the 2027 *Provider & Pharmacy Directory* to see if your providers are in our network.
Wellcare Spendables®	Items purchased in store or online may be returned following the retailers return and exchange policies.	Items purchased online are final sale. If item is damaged or spoiled, please call Member Services at the number at the bottom of the page.

F. Choosing a plan

F1. Staying in our plan

We hope to keep you as a plan member. You don't have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you'll automatically stay enrolled as a member of our plan for 2027.

If you decide to stay with our plan, your STAR+PLUS plan will remain the same and you don't have to take any action.

F2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you have STAR+PLUS, you have some choices to end your membership in our plan, including any month of the year. If you decide to change your Medicare plan to another Medicare plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan, your STAR+PLUS plan will automatically change to the same plan that also provides your Medicare benefits. You don't have to take any action for this to occur. In addition, you may end your membership in our plan during the following periods:

- The **Open Enrollment Period** lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period** lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for STAR+PLUS or Extra Help changed, **or**
- you recently moved into or are currently getting care in an institution (like a skilled nursing facility or a long-term care hospital). If you recently moved out of an institution, you can change plans or change to Original Medicare for two full months after the month you move out.

For additional information on changing your plan, please see the table below.

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section F2**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan. If you choose another Medicare plan that also provides your STAR+PLUS benefits, your STAR+PLUS plan will also change to the same plan that provides your Medicare benefits. You don't need to take any action for this to occur.** **Or** **You can enroll in the Program of All-Inclusive Care for the Elderly (PACE). PACE is available in Potter, Randall, El Paso, and Lubbock Counties. If you choose to enroll in PACE, the benefits include, but aren't limited to, all Medicaid and Medicare covered services including prescription drugs. You must receive all needed health care services, including primary care and specialist physician services (other than emergency services), from the PACE organization or an entity authorized by the PACE organization.** **To get more information about PACE, call Texas PACE Program at 1-512-487-3450.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8 a.m. to 5 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a local Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/services/health/medicare. **OR** Enroll in a plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan. If you enroll in a new plan, you'll automatically be disenrolled from our plan when your new plan's coverage begins.

2. You can change to: **Original Medicare with a separate Medicare drug plan.** **If you choose to move to Original Medicare, your STAR+PLUS plan will remain the same. You don't have to take any action for this to occur.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8 a.m. to 5 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/services/health/medicare. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan for your Medicare benefits when your Original Medicare coverage begins, but you'll continue to be enrolled in our STAR+PLUS plan for your Medicaid benefits. You don't have to take any action for this to occur.

3. You can change to: **Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason** **If you choose to move to Original Medicare, your STAR+PLUS plan will remain the same. You don't have to take any action for this to occur.** **NOTE**: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, from 8 a.m. to 5 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/services/health/medicare.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8 a.m. to 5 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/services/health/medicare. You'll automatically be disenrolled from our plan for your Medicare benefits when your Original Medicare coverage begins, but you'll continue to be enrolled in our STAR+PLUS plan for your Medicaid benefits. You don't have to take any action for this to occur.

4. You can change to: **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section G2**. If you choose another Medicare plan that also provides your STAR+PLUS benefits during certain times of the year, your STAR+PLUS plan will also change to the same plan that provides your Medicare benefits. You don't need to take any action for this to occur. If you choose to enroll in any other Medicare health plan, such as a Medicare Advantage Plan (MAP) or Original Medicare, during certain times of the year, then your STAR+PLUS plan will remain the same. In this situation, if you want to change your STAR+PLUS plan, you can change at any time by contacting the Texas Enrollment Broker 800-964-2777, 8 a.m. to 6 p.m. CST, Monday-Friday. Call 1-855-445-3556 (TTY 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. Please note during after hours, weekends and federal holidays from April 1 to September 30, our automated phone system may answer your call. If you leave a voicemail message, please include your name, and telephone number and a team member will return your call within one (1) business day.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-512-487-3450. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8 a.m. to 5 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/services/health/medicare. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. If you choose another Medicare plan that also provides your STAR+PLUS benefits, you don't need to take any action for your STAR+PLUS plan to automatically align with your new Medicare plan. If you choose to enroll in any other Medicare health plan, such as a Medicare

	Advantage Plan (MAP) or Original Medicare, then your STAR+PLUS plan will remain the same. If you want to change your STAR+PLUS plan, you can change at any time by contacting the Texas Enrollment Broker 800-964-2777, 8 a.m. to 6 p.m. CST, Monday-Friday.

Your STAR+PLUS services

For questions about how to get your STAR+PLUS services after you leave our plan, call the Texas Enrollment Broker at 800-964-2777 or TTY: 711, 8 a.m. to 6 p.m. CST, Monday-Friday. Ask how joining another plan or returning to Original Medicare affects how you get your STAR+PLUS coverage.

G. Getting help

G1. Our plan

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Member Handbook*

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits for 2027. It explains your rights and the rules to follow to get services and drugs we cover.

The *Member Handbook* for 2027 will be available by October 15. An up-to-date copy of the *Member Handbook* is available on our website at go.wellcare.com/TX. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2027.

Our website

You can visit our website at go.wellcare.com/TX. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List* (*List of Covered Drugs*).

G2. Health Information Counseling & Advocacy Program of Texas (HICAP)

You can also call the state health insurance program (SHIP). In Texas the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). The HICAP has trained counselors who can help you understand your plan choices and answer questions about switching plans. The HICAP isn't connected with us or with any insurance company or health plan, and HICAP's services are free.

For more information or to find a local HICAP office in your area, call 1-800-252-9240, Monday-Friday, 8 a.m. to 5 p.m. CST, or visit www.hhs.texas.gov/services/health/medicare.

G3. Health and Human Services (HHS) Office of the Ombudsman

The HHS Office of the Ombudsman helps STAR+PLUS members answer questions and file complaints about STAR+PLUS services, for example, nursing Services, minor home modifications, and adaptive aids.

- The ombudsman's services are free.
- They can answer questions if you have a problem or complaint about your STAR+PLUS services and can help you understand what to do.
- The HHS Office of the Ombudsman can help you file a complaint and understand your appeal rights with our plan related to your STAR+PLUS services. They can help you if you are having a problem with STAR+PLUS.
- The HHS Office of the Ombudsman makes sure you have information related to your rights and protections and how you can get your concerns related to your STAR+PLUS services resolved.
- The HHS Office of the Ombudsman isn't connected with us or with any insurance company or health plan. The phone number for the HHS Office of the Ombudsman is 1-866-566-8989 or TTY 1-800-735-2989.

G4. Medicare

To get information directly from Medicare:

- call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048
- chat live at www.Medicare.gov/talk-to-someone
- write to Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare's Website

You can visit the Medicare website (www.medicare.gov). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to www.medicare.gov and click on "Find plans.")

Medicare & You 2027

You can read the *Medicare & You 2027* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G5. STAR+PLUS

You can visit the STAR+PLUS website for general information about the benefits and services offered through the program, www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/starplus.

If you choose to disenroll from our STAR+PLUS plan and need more information on how to join another plan or returning to Original Medicare affects how you get your Medicaid services, call Texas Enrollment Broker 800-964-2777, 8 a.m. to 6 p.m. Central Time, Monday through Friday.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1444. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850*