Wellcare Simple Open (PPO) offered by Sunflower State Health Plan, Inc.

Annual Notice of Change for 2026

You're enrolled as a member of Wellcare Simple Open (PPO).

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, 2025, you'll stay in Wellcare Simple Open (PPO).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* 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/KS or call Member Services at 1-800-977-7522 (TTY users call 711) to get a copy by mail.

More Resources

- Call Member Services at 1-800-977-7522 (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 must provide information in a way that works for you (in languages other than English, in braille, in audio, in large print, or other alternate formats, etc.). Please call Member Services if you need plan information in another format.

About Wellcare Simple Open (PPO)

- Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.
- When this material says "we," "us," or "our," it means Sunflower State Health Plan, Inc. When it says "plan" or "our plan," it means Wellcare Simple Open (PPO).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in** Wellcare Simple Open (PPO). Starting January 1, 2026, you'll get your medical and drug coverage through Wellcare Simple Open (PPO). 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 2026

	2025 (this year)	**2026 (next year)**
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	$0	**$0**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $3,900 From network and out-of-network providers combined: $6,200	**From network providers: $4,500** **From network and out-of-network providers combined: $6,800**
Primary care office visits	**In-Network** $0 copay per visit **Out-of-Network** $40 copay per visit	**In-Network** **$0 copay per visit** **Out-of-Network** **$40 copay per visit**
Specialist office visits	**In-Network** $25 copay per visit **Out-of-Network** $75 copay per visit	**In-Network** **$25 copay per visit** **Out-of-Network** **$75 copay per visit**

	2025 (this year)	2026 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	For covered admissions, per admission: **In-Network:** $350 copay per day, for days 1 to 7 and a $0 copay per day, for days 8 to 90 for each covered hospital stay **Out-of-Network:** 45% of the total cost for days 1 to 90 for each covered hospital stay	**For covered admissions, per admission:** **In-Network:** **$375 copay per day, for days 1 to 8 and a $0 copay per day, for days 9 to 90 for each covered hospital stay** **Out-of-Network:** **45% of the total cost for days 1 to 90 for each covered hospital stay**
Part D drug coverage deductible (Go to Section 1.7 for details.)	$420 except for covered insulin products and most adult Part D vaccines.	**$615 except for covered insulin products and most adult Part D vaccines.**
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: Standard cost sharing: $5 copay for a one-month (30-day) supply. Preferred cost sharing: $0 copay for a one-month (30-day) supply. Drug Tier 2: Standard cost sharing:	**Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** **Standard cost sharing: $5 copay for a one-month (30-day) supply.** **Preferred cost sharing: $0 copay for a one-month (30-day) supply.**

	2025 (this year)	2026 (next year)
	$10 copay for a one-month (30-day) supply. Preferred cost sharing: $0 copay for a one-month (30-day) supply. Drug Tier 3: Standard cost sharing: 25% of the total cost for a one-month (30-day) supply. You pay $35 per month supply of each covered insulin product on this tier. Preferred cost sharing: 25% of the total cost for a one-month (30-day) supply. You pay $35 per month supply of each covered insulin product on this tier. Drug Tier 4: Standard cost sharing: 40% of the total cost for a one-month (30-day) supply. You pay $35 per month supply of each covered insulin product on this tier.	**Drug Tier 2:** **Standard cost sharing: $10 copay for a one-month (30-day) supply.** **Preferred cost sharing: $0 copay for a one-month (30-day) supply.** **Drug Tier 3:** **Standard cost sharing: 25% of the total cost for a one-month (30-day) supply.** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **Preferred cost sharing: 25% of the total cost for a one-month (30-day) supply.** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **Drug Tier 4:**

	2025 (this year)	2026 (next year)
	Preferred cost sharing: 40% of the total cost for a one-month (30-day) supply. You pay $35 per month supply of each covered insulin product on this tier. Drug Tier 5: Standard cost sharing: 28% of the total cost for a one-month (30-day) supply. Preferred cost sharing: 28% of the total cost for a one-month (30-day) supply. Drug Tier 6: Standard cost sharing: $0 copay for a one-month (30-day) supply. Preferred cost sharing: $0 copay for a one-month (30-day) supply.	**Standard cost sharing: 34% of the total cost for a one-month (30-day) supply.** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **Preferred cost sharing: 33% of the total cost for a one-month (30-day) supply.** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **Drug Tier 5:** **Standard cost sharing: 25% of the total cost for a one-month (30-day) supply.** **Preferred cost sharing: 25% of the total cost for a one-month (30-day) supply.** **Drug Tier 6:** **Standard cost sharing:**

	2025 (this year)	2026 (next year)
		$0 copay for a one-month (30-day) supply. **Preferred cost sharing:** **$0 copay for a one-month (30-day) supply.**
	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.	**Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	**$0**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

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.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Our costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$3,900	**$4,500** **Once you've paid $4,500 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.**
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	$6,200	**$6,800** **Once you've paid $6,800 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.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider & Pharmacy Directory* go.wellcare.com/2026providerdirectories 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/2026providerdirectories.
- Call Member Services at 1-800-977-7522 (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 1-800-977-7522 (TTY users call 711) for help.

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 2026 *Provider & Pharmacy Directory* go.wellcare.com/2026providerdirectories 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/2026providerdirectories.
- Call Member Services at 1-800-977-7522 (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 1-800-977-7522 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	**2026 (next year)**
Prior Authorizations	The following in-network benefits have a change in prior authorization requirements.	
	Physician/Practitioner services, including doctor's office visits - Additional telehealth services may require prior authorization. Vision care - Medicare-covered eyewear	**Physician/Practitioner services, including doctor's office visits - Additional telehealth services do(es) not require prior authorization.** **Vision care - Medicare-covered eyewear**

	2025 (this year)	2026 (next year)
	may require prior authorization. If your benefit does or does not require a prior authorization, it may still require a referral from the plan.	**do(es) <u>not</u> require prior authorization.** **If your benefit does or does not require a prior authorization, it may still require a referral from the plan.**
Acupuncture for chronic low back pain	**In-Network** You pay a $0 copay for Medicare-covered acupuncture received in a PCP office. You pay a $25 copay for Medicare-covered acupuncture received in a specialist office. You pay a $20 copay for Medicare-covered acupuncture received in a chiropractor office.	**In-Network** **You pay a $0 copay for Medicare-covered acupuncture received in a PCP office.** **You pay a $25 copay for Medicare-covered acupuncture received in a specialist office.** **You pay a $15 copay for Medicare-covered acupuncture received in a chiropractor office.**
Cardiac rehabilitation services - Intensive	**In-Network** You pay a $5 copay for each Medicare-covered service.	**In-Network** **You pay a $50 copay for each Medicare-covered service.**
Cardiac rehabilitation services	**In-Network** You pay a $5 copay for each Medicare-covered service.	**In-Network** **You pay a $40 copay for each Medicare-covered service.**

	2025 (this year)	2026 (next year)
Chiropractic services	**In-Network** You pay a $20 copay for each Medicare-covered service.	**In-Network** **You pay a $15 copay for each Medicare-covered service.**
Diagnostic Colonoscopy	**In-Network** You pay a $0 copay for each Medicare-covered diagnostic colonoscopy in an outpatient hospital facility. You pay a $245 copay for each Medicare-covered diagnostic colonoscopy in an ambulatory surgical center.	**In-Network** **You pay a $0 copay for each Medicare-covered diagnostic colonoscopy regardless of place of service.**
Emergency services	You pay a $140 copay for each Medicare-covered service. Copayment is waived if you are admitted to a hospital within 24 hours.	**You pay a $130 copay for each Medicare-covered service.** **Copayment is waived if you are admitted to a hospital within 24 hours.**
Emergency services - Worldwide emergency coverage	You pay a $140 copay for each covered service. Copayment is not waived if you are admitted to the hospital.	**You pay a $130 copay for each covered service.** **Copayment is not waived if you are admitted to the hospital.**
Emergency services - Worldwide urgent coverage	You pay a $140 copay for each covered service. Copayment is not waived if you are admitted to a hospital.	**You pay a $130 copay for each covered service.** **Copayment is not waived if you are admitted to a hospital.**

	2025 **(this year)**	**2026** **(next year)**
Inpatient hospital care	For covered admissions, per admission: **In-Network** You pay a $350 copay per day, for days 1 to 7 and a $0 copay per day, for days 8 to 90 for each covered hospital stay	**For covered admissions, per admission:** **In-Network** **You pay a $375 copay per day, for days 1 to 8 and a $0 copay per day, for days 9 to 90 for each covered hospital stay**
Inpatient services in a psychiatric hospital	For Medicare-covered admissions, per admission: **In-Network** You pay a $350 copay per day, for days 1 to 7 and a $0 copay per day, for days 8 to 90 for each Medicare-covered hospital stay	**For Medicare-covered admissions, per admission:** **In-Network** **You pay a $290 copay per day, for days 1 to 8 and a $0 copay per day, for days 9 to 90 for each Medicare-covered hospital stay**
Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services	**In-Network** You pay a $75 copay for each Medicare-covered service.	**In-Network** **You pay a $50 copay for each Medicare-covered service.**

	2025 (this year)	2026 (next year)
Outpatient hospital observation	**In-Network** You pay a $140 copay for outpatient observation services when you enter observation status through an emergency room. You pay a $375 copay for outpatient observation services when you enter observation status through an outpatient facility.	**In-Network** **You pay a $130 copay for outpatient observation services when you enter observation status through an emergency room.** **You pay a $375 copay for outpatient observation services when you enter observation status through an outpatient facility.**
Partial hospitalization and Intensive outpatient program services	**In-Network** You pay a $130 copay per day for each Medicare-covered service.	**In-Network** **You pay a $140 copay per day for each Medicare-covered service.**
Personal Emergency Response System (Medical Alert)	Personal Emergency Response System is not covered.	**You pay a $0 copay.**
Podiatry services - Medicare-covered	**Out-of-Network** You pay a $75 copay for each Medicare-covered service.	**Out-of-Network** **You pay 45% of the total cost for each Medicare-covered service.**
Pulmonary Rehabilitation Services	**In-Network** You pay a $5 copay for each Medicare-covered service.	**In-Network** **You pay a $35 copay for each Medicare-covered service.**

	2025 (this year)	2026 (next year)
Skilled nursing facility (SNF) care	For Medicare-covered admissions, per admission: **In-Network** You pay a $0 copay per day, for days 1 to 20, a $214 copay per day, for days 21 to 50, and a $0 copay per day, for days 51 to 100 for Medicare-covered skilled nursing facility care. Beyond day 100: You are responsible for all costs.	**For Medicare-covered admissions, per admission:** **In-Network** **You pay a $0 copay per day, for days 1 to 20, a $218 copay per day, for days 21 to 50, and a $0 copay per day, for days 51 to 100 for Medicare-covered skilled nursing facility care.** **Beyond day 100: You are responsible for all costs.**
Supervised Exercise Therapy (SET)	**In-Network** You pay a $5 copay for each Medicare-covered service.	**In-Network** **You pay a $25 copay for each Medicare-covered service.**
Wellcare Spendables®	You pay a $0 copay. You receive a $30 quarterly allowance to be used towards over-the-counter (OTC) items. The allowance will be automatically loaded onto your Wellcare Spendables® card at the beginning of each quarter. Any unused allowance amount will expire at the end of every quarter. **Over-the-Counter items (OTC)** You can use your Wellcare Spendables® card on plan-approved over-the-counter items. Your	**You pay a $0 copay. You will receive a $15 monthly allowance preloaded on your Wellcare Spendables® card to spend on OTC items, Dental, Vision, and Hearing services. Your monthly allowance rolls over to the following month if unused and expires at the end of the plan year.** **Your card allowance can be used towards:** **Over-the-Counter items (OTC)** **You can use your card at**

	2025 (this year)	2026 (next year)
	card can be used at participating retail locations, online or via mobile app for home delivery. **Dental, Vision and Hearing** Wellcare Spendables® card allowance cannot be used toward any dental, vision, or hearing service expenses.	**participating retail locations, through the mobile app, or by logging in to your member portal to place an order for home delivery.** **Dental, Vision, and Hearing** **You may use your card to help reduce your out-of-pocket expenses for any dental, vision, and/or hearing services. The card may be used to pay your dental, vision, or hearing provider directly. Please refer to your Evidence of Coverage for more information.**

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 1-800-977-7522 (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, 2025, call Member Services at 1-800-977-7522 (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. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), 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 $2,100.

- ***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 generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic

Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage

	2025 (this year)	**2026 (next year)**
Yearly Deductible	$420 During this stage, you pay $5 *standard cost sharing* or $0 *preferred cost sharing* for drugs on Tier 1: Preferred Generic, $10 *standard cost sharing* or $0 *preferred cost sharing* for drugs on Tier 2: Generic, and $0 *cost sharing* for drugs on Tier 6: Select Care Drugs and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you've reached the yearly deductible.	**$615** **During this stage, you pay $5 *standard cost sharing* or $0 *preferred cost sharing* for drugs on Tier 1: Preferred Generic, $10 *standard cost sharing* or $0 *preferred cost sharing* for drugs on Tier 2: Generic, and $0 *cost sharing* for drugs on Tier 6: Select Care Drugs and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you've reached the yearly deductible.**

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. 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 $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	**2026 (next year)**
Drug Tier 1 - Preferred Generic:	*Standard cost sharing:* You pay a $5 copay Your cost for a one-month (30-day) mail-order prescription is $5. *Preferred cost sharing:* You pay a $0 copay Your cost for a one-month (30-day) mail-order prescription is $0.	***Standard cost sharing:*** **You pay a $5 copay** **A one-month (30-day) mail-order prescription is <u>not</u> covered.** ***Preferred cost sharing:*** **You pay a $0 copay** **A one-month (30-day) mail-order prescription is <u>not</u> covered.**
Drug Tier 2 - Generic:	*Standard cost sharing:* You pay a $10 copay Your cost for a one-month (30-day) mail-order prescription is $10. *Preferred cost sharing:* You pay a $0 copay Your cost for a one-month (30-day) mail-order prescription is $0.	***Standard cost sharing:*** **You pay a $10 copay** **A one-month (30-day) mail-order prescription is <u>not</u> covered.** ***Preferred cost sharing:*** **You pay a $0 copay** **A one-month (30-day) mail-order prescription is <u>not</u> covered.**

	2025 (this year)	**2026 (next year)**
Drug Tier 3 - Preferred Brand:	*Standard cost sharing:* You pay 25% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month (30-day) mail-order prescription is 25%. *Preferred cost sharing:* You pay 25% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month (30-day) mail-order prescription is 25%.	***Standard cost sharing:* You pay 25% of the total cost** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **A one-month (30-day) mail-order prescription is <u>not</u> covered.** ***Preferred cost sharing:* You pay 25% of the total cost** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **A one-month (30-day) mail-order prescription is <u>not</u> covered.**

	2025 **(this year)**	**2026** **(next year)**
Drug Tier 4 - Non-Preferred Drug:	*Standard cost sharing:* You pay 40% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month (30-day) mail-order prescription is 40%. *Preferred cost sharing:* You pay 40% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month (30-day) mail-order prescription is 40%.	***Standard cost sharing:* You pay 34% of the total cost** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **A one-month (30-day) mail-order prescription is <u>not</u> covered.** ***Preferred cost sharing:* You pay 33% of the total cost** **You pay the lesser of $35 or 25% per month supply of each covered insulin product on this tier.** **A one-month (30-day) mail-order prescription is <u>not</u> covered.**
Drug Tier 5 - Specialty Tier:	*Standard cost sharing:* You pay 28% of the total cost Your cost for a one-month (30-day) mail-order prescription is 28%. *Preferred cost sharing:* You pay 28% of the total cost Your cost for a one-month (30-day) mail-order prescription is 28%.	***Standard cost sharing:* You pay 25% of the total cost** **A one-month (30-day) mail-order prescription is <u>not</u> covered.** ***Preferred cost sharing:* You pay 25% of the total cost** **A one-month (30-day) mail-order prescription is <u>not</u> covered.**

	2025 (this year)	**2026 (next year)**
Drug Tier 6 - Select Care Drugs:	*Standard cost sharing:* You pay a $0 copay Your cost for a one-month (30-day) mail-order prescription is $0. *Preferred cost sharing:* You pay a $0 copay Your cost for a one-month (30-day) mail-order prescription is $0.	***Standard cost sharing:*** **You pay a $0 copay** **A one-month (30-day) mail-order prescription is <u>not</u> covered.** ***Preferred cost sharing:*** **You pay a $0 copay** **A one-month (30-day) mail-order prescription is <u>not</u> covered.**

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

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.

	2025 (this year)	2026 (next year)
Advance Coverage Determination Request	Members could request a Coverage Determination prior to the upcoming benefit year effective date.	**Members can request a Coverage Determination on or after 1/1/2026. Any request submitted prior to this date will only be evaluated for the current benefit year.**

	2025 (this year)	2026 (next year)
Membership disenrollment options	If you need to switch from our plan to Original Medicare or another Medicare Advantage plan, you need to send us a written request to disenroll. For more details, please refer to Chapter 10 of your Evidence of Coverage.	**If you need to switch from our plan to Original Medicare or another Medicare Advantage plan, you can send us a written request to disenroll or visit our website to disenroll online. For more details, please refer to Chapter 10 of your Evidence of Coverage.**
Preferred Part B Diabetic Products	OneTouch™ is our preferred diabetic testing supplies (glucose monitors & test strips) brand. Other brands are not covered unless medically necessary and authorized.	**Accu-Chek Guide™ and True Metrix™ are our preferred diabetic testing supplies (glucose monitors & test strips) brands. Other brands are not covered unless medically necessary and authorized.**
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in 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 2026.** **To learn more about this payment option, call us at 1-833-750-9969. (TTY users call 1-800-716-3231.) or visit www.Medicare.gov.**

SECTION 3 How to Change Plans

To stay in Wellcare Simple Open (PPO), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our Wellcare Simple Open (PPO).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Wellcare Simple Open (PPO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Wellcare Simple Open (PPO).
- **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/KS. Call Member Services at 1-800-977-7522 (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. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* 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, 2026, 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, 2026.

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

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

- Have Medicaid
- Get Extra Help paying for their drugs

- Have or are leaving employer coverage
- Move out of our plan's service area

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

You can 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 call 1-800-325-0778.
    - Your State Medicaid Office.
- **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 Ryan White Part B Program. 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 Ryan White Part B Program at 1-785-296-1086 (TTY 711) from 8 a.m. - 5 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. **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. All members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-833-750-9969 (TTY users should call 1-800-716-3231) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from Wellcare Simple Open (PPO)

- **Call Member Services at 1-800-977-7522. (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 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Wellcare Simple Open (PPO). 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/KS or call Member Services at 1-800-977-7522 (TTY users call 711) to ask us to mail you a copy.

- **Visit** go.wellcare.com/KS

  Our website has the most up-to-date information about our provider network (*Provider Directory/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 Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).

Call Senior Health Insurance Counseling for Kansas (SHICK) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Senior Health Insurance Counseling for Kansas (SHICK) at 1-800-860-5260. Learn more about Senior Health Insurance Counseling for Kansas (SHICK) by visiting https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick.

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 www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

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

- **Visit 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 2026***

  The *Medicare & You 2026* 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 www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.