Wellcare Meridian Dual Align (HMO D-SNP) offered by Meridian Health Plan of Michigan, 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 and rules. 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/MeridianMI. 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

- You can get this Annual Notice of Change for free in other formats, such as large print, braille, or audio. Call 1-844-536-2168 (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 or in an alternate format if you ask for it this way. This is called a “standing request”. We will document your choice.
    - 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.

For questions about or problems with the MI Coordinated Health program or our plan, contact the MI Community, Home, and Health Ombudsman (MI CHHO) for free help. MI CHHO is an independent program and isn’t connected with this plan. Call 1-888-746-6456 or visit the MI CHHO website at meji.org/michho/mhlo. To schedule an appointment with a person-centered options counselor, please call MI Options at 1-800-803-7174 8 a.m. to 8 p.m., Monday through Friday.

Table of Contents

A. Disclaimers....4

B. Reviewing your Medicare and Michigan Medicaid coverage for next year....4

B1. Information about Wellcare Meridian Dual Align (HMO D-SNP)....5

B2. Important things to do....5

C. Changes to our network providers and pharmacies....6

D. Changes to benefits for next year....7

D1. Changes to benefits for medical services....7

D2. Changes to drug coverage....14

E. Administrative changes....18

F. Choosing a plan....18

F1. Staying in our plan....18

F2. Changing plans....18

G. Getting help....24

G1. Our plan....24

G2. MI Options....24

G3. The MI Community, Home, and Health Ombudsman....24

G4. Medicare....25

G5. Michigan Medicaid....25

A. Disclaimers

- Wellcare Meridian Dual Align (HMO D-SNP) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to members. Enrollment in our plan depends on contract renewal.
- Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.
- Based on a Model of Care review, Wellcare Meridian 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.

B. Reviewing your Medicare and Michigan 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.

Wellcare Meridian Dual Align (HMO D-SNP) is part of the MI Coordinated Health (MICH) program. MICH is a highly integrated dual eligible special needs plan (HIDE SNP) that provides benefits of both Medicare and Medicaid to enrollees.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You'll still be in the Medicare and Michigan Medicaid 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**.
- Michigan Medicaid and options and services in **Section F2**.

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

- Wellcare Meridian Dual Align (HMO D-SNP) is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members. Enrollment depends on contract renewal.
- When this *Annual Notice of Change* says "we," "us," "our," or "our plan," it means Wellcare Meridian 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 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 do the total costs compare to other coverage options?
- **Think about whether you're happy with our plan.**

If you decide to stay with Wellcare Meridian 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 Meridian Dual Align (HMO D-SNP).	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.

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 provider, 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 for next year

D1. Changes to benefits for medical services

We're changing our coverage for certain medical services and what you pay for these covered 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	The following in-network benefits have a change in referral requirements.	
	Certain Medicare-covered services* do not require a referral.	Certain Medicare-covered services* may require a referral.

	2026 (this year)	2027 (next year)
Fitness benefit	You pay a **$0** copay for the fitness benefit. 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.	You pay a **$0** copay for the fitness benefit. The fitness benefit offers access to a wide network of participating fitness centers including standard and premium gyms and fitness studios. Membership at standard gyms includes standard amenities and services. Fitness studios offer class-based programs such as yoga, Pilates, and strength training. You may access one or more gyms within the fitness network. Members also have access to digital resources through virtual classes, on-demand videos and mobile app, cognitive fitness program, local health and wellness activities, and choice of a home fitness kit
Hearing services – Routine hearing exam and hearing aids **(continued to the next page)**	You pay a **$0** copay for routine hearing services under your Medicare coverage for the following: Hearing exam – 1 every year Fitting/evaluation – 1 every year	Routine hearing services **isn't** covered under your Medicare coverage.

	2026 (this year)	2027 (next year)
Hearing services – Routine hearing exam and hearing aids (continued)	Hearing aids – 2 (1 per ear) every year with a maximum allowance of $1,500 per hearing aid.	
In-Home Support Services	You pay a **$0** copay for 12 visits every year. Services include cleaning, household chores and meal preparation.	In-home support service **isn't** covered under your Medicare coverage.
Meals – chronic (limitations and exclusions apply)	You pay a **$0** copay for chronic meals. 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.	Meals - chronic **isn't** covered under your Medicare coverage.
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 up to 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 meals - post-acute. There is a maximum of 2 meals per day for up to 14 days, for a total of 28 meals. Service must be requested within 45 days of discharge from your inpatient stay.

	2026 (this year)	2027 (next year)
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.	Personal emergency response system **isn't** covered under your Medicare coverage.
Routine dental services (continued on the next page)	You pay a **$0** copay of the total cost. **Preventive services:** Oral exam* Dental X-rays* Other diagnostic services* Other preventive services* **Comprehensive services (limited to $5,000 allowance every year):** Restorative services* Endodontics* Periodontics* Prosthodontics removable* Prosthodontics fixed* Oral/maxillofacial surgery* Adjunctive general services – every date of service to 24 months depending on type of service. *Benefit frequency limits vary	You pay a **$0** copay of the total cost. **Preventive services:** Oral exam* Dental X-rays* Other diagnostic services* Other preventive services* **Comprehensive services (limited to $5,000 allowance every year):** Restorative services* Endodontics* Periodontics* Prosthodontics removable* Prosthodontics fixed* Oral/maxillofacial surgery* Adjunctive general services – every date of service to 5 years depending on type of service. *Benefit frequency limits vary based on services you receive.

	2026 (this year)	2027 (next year)
Routine dental services (continued)	based on services you receive. Refer to the *Member Handbook* for more details.	Refer to the *Member Handbook* for more details.
Special Supplemental Benefits for the Chronically Ill (SSBCI) – Qualifying Conditions	The following are <u>not</u> 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) (continued on the next page) 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	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	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

	2026 (this year)	2027 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI) (continued) 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 *Member Handbook*.	Safety Items and Services • Pest Control Items and Services • Rent Assistance • Utility Assistance The following benefits are <u>not</u> covered: • Personal Care Items • Robotic Companion Pets Please see your M*ember Handbook* for more information.	• Rent Assistance • Robotic Companion Pets • Utility Assistance The following benefits are not covered: • Home Assistance and Safety Items and Services • Pest Control Services Please see your *Member Handbook* for more information.

	2026 (this year)	2027 (next year)
Wellcare Spendables® (continued on the next page)	You pay a **$0** copay. You receive a $229 monthly allowance. Your allowance will be available at the beginning of each month. Any unused amount will roll over into the next month and will expire at the end of the plan year. 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 $218 monthly allowance. Your allowance will be available at the beginning of each month. Any unused amount will roll over into the next month and will expire at the end of the plan year. Your allowance can be used toward: • Over-the-counter items (OTC) • SSBCI benefits (for member who qualify) Expenses for dental, vision and hearing are not 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-11.

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 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 and/or the state 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 care 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 2027 *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 6 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 is **$0**.	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**.	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**.	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	Your copay for a one-month (30-day) supply is **$0**.	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**.	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**.	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)
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.

F2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you're enrolled in Wellcare Meridian Dual Align (HMO D-SNP), you have some choices to end your membership in our plan including any month of the year.

In addition, you may end your membership in our plan during the following periods:

- The **Open Enrollment Period**, which 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**, which 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 Michigan Medicaid 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.

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 Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.**	**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 855-445-4554. If you need help or more information: • Call MI Options at 1-800-803-7174. For more information or to find a local MI Options office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program. **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins. You can also contact the plan you wish to enroll in directly.

2. You can change to: **Original Medicare with a separate Medicare drug plan** **To apply for Medicaid, complete an application online at** www.michigan.gov/mibridges.	**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 MI Options at 1-800-803-7174 For more information or to find a local MI Options office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason** **To apply for Medicaid, complete an application online at** www.michigan.gov/mibridges. **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 MI Options at 1-800-803-7174 (TTY: 1-888-263-5897) 8 a.m. - 7 p.m. local time, Monday - Friday (except holidays) or visit www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program.	**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 MI Options at 1-800-803-7174 For more information or to find a local office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. You can change to:	**Here is what to do:**
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 F2**.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 855-445-4554. If you need help or more information: • Call MI Options at 1-800-803-7174 **OR** Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins.

Your Michigan Medicaid services

For questions about how to get your Michigan Medicaid services after you leave our plan, contact the Beneficiary Help Line: 1-800-642-3195 or beneficiarysupport@michigan.gov. For more information log on to www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support. Ask how joining another plan or returning to Original Medicare affects how you get your Michigan Medicaid 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/MeridianMI. 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/MeridianMI. 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. MI Options

You can also call the state health insurance program (SHIP). In Michigan the SHIP is called MI Options. MI Options can help you understand your plan choices and answer questions about switching plans. MI Options isn't connected with us or with any insurance company or health plan. MI Options has trained counselors and services are free. MI Options phone number is 1-800-803-7174 (TTY: 1-888-263-5897). For more information or to find a local MI Options office in your area, please visit www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/long-term-services-and-supports.

G3. The MI Community, Home, and Health Ombudsman

The MI Community, Home, and Health Ombudsman (MI CHHO) serves as an advocate and problem-solver for people enrolled in MICH program. MI CHHO isn't connected with any insurance company or health plan and all of its services are free and it keeps all information confidential. Call the MI CHHO if you have trouble or delay with your plan providing medical care, services, equipment, other benefits, or with the quality of care. MI CHHO can also help you learn about the MICH program and options for care in the community, including your rights.

You can call MI CHHO if your plan has denied medical care, services, equipment, or other benefits - including help with appeals.

Contact us at our toll-free hotline at:1-888-746-6456

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. Michigan Medicaid

Michigan Medicaid is a health care program that provides comprehensive health care services to low income adults and children. Services covered by Medicaid are offered through what's called fee-for-service or through Medicaid Managed Care Organizations

- Fee-for-service is the term for Medicaid paid services that aren't provided through a health plan. This means that Medicaid pays for the service. People under fee-for-service will use the www.michigan.gov/mdhhs/assistance-programs/healthcare/adults/quicklinks/the-mihealth-card card to receive services.
- Additional information regarding Michigan Medicaid can be found by accessing the following website www.michigan.gov/mdhhs/assistance-programs/healthcare.
- People may join a health plan. The health plan pays for most of the services. For people to choose to join a health plan, Michigan Enrolls will send a letter with more information. After enrollment with a health plan, both the MIhealth card and the health plan card are needed to access services. For additional information regarding joining a health plan, please visit the following website www.michigan.gov/mdhhs/assistance-programs/healthcare

Costs

People with Medicaid and Medicare that are enrolled in a HIDE SNP, such as our plan, won't have premiums, co-pays, cost-sharing, coinsurance, or deductibles for in-network services, except in some instances for Medicare Part D drugs. Individuals with Pre-Eligibility Medical Expenses (PEME) and Patient Pay Amounts (PPAs) are still required to pay these expenses when enrolled in a HIDE SNP. If you disenroll from our HIDE SNP, you may have to pay a small amount called a co-pay. People age 21 and older may have a co-pay for the services listed in the Beneficiary Co-Payment Requirements. To see a list of co-pay amounts in this chart, please visit www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder60/WebCo-PayTable_11-02-06.pdf?rev=39dfeae1839e4434b66f503f84d63e45&hash=18CE85BF53B120E81739BD1F781CE2B8.

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