

AmeriHealth Caritas VIP Care (HMO-SNP) offered by Vista Health Plan Inc.

Annual Notice of Change for 2026

You're enrolled as a member of AmeriHealth Caritas VIP Care (HMO-SNP).

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

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in AmeriHealth Caritas VIP Care
- 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 www.amerihhealthcaritasvipcare.com/pa or call Member Services at 1-866-533-5490 (TTY users call 711) to get a copy by mail.

More Resources

- Call Member Services at 1-866-533-5490 (TTY users call 711 for more information. Hours are October 1 – March 31: 8 a.m. - 8 p.m., seven days a week April 1 – September 30: 8 a.m. - 8 p.m., Monday through Friday This call is free.
- Please contact Member Services if you require this document in an alternative format such as large font, Braille, or audio.

About AmeriHealth Caritas VIP Care

- AmeriHealth Caritas VIP Care is an HMO-SNP plan with a Medicare contract and a contract with the Pennsylvania Medicaid program. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal. Our plan also has a written agreement with the Pennsylvania. Medicaid program to coordinate your Medicaid benefits.
- When this material says “we,” “us,” or “our,” it means Vista Health Plan, Inc. When it says “plan” or “our plan,” it means AmeriHealth Caritas VIP Care.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in AmeriHealth Caritas VIP Care** Starting January 1, 2026, you'll get your medical and

drug coverage through AmeriHealth Caritas VIP Care. Go to Section 2 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 <u>most</u> you'll pay out of pocket for services. (Go to Section 1.2 for details.)	\$9,350 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	\$9,250 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	\$0 per visit	\$0 per visit
Specialist office visits	\$0 per visit	\$0 per visit
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	\$0 copay	\$0 copay

	2025 (this year)	2026 (next year)
you're discharged is your last inpatient day.		
Part D drug coverage deductible (Go to Section 1.6 for details.)	Deductible: \$590 except for insulin furnished through an item of durable medical equipment.	Deductible: \$615 except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment during the Initial Coverage Stage: You Pay \$0 per prescription. Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Drug Tier 1 – Preferred Generic: 25% of the total cost. Drug Tier 2 – Generic: You pay 25% of the total cost. Except for covered insulin products and most adult Part D vaccines. You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 3 – Preferred Brand: You pay 25% of the total cost. Except for covered insulin products and most adult Part D vaccines. You pay no more than \$35 per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
		Drug Tier 4 – Non-Preferred Drug: You pay 25% of the total cost. Except for covered insulin products and most adult Part D vaccines. You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 5 – Specialty: You pay 25% of the total cost. Drug Tier 6 – Select Care Drugs: You pay \$0 of the total cost.

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 unless it's paid for you by Medicaid.)	\$0	\$0

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$9,350	\$9,250 Once you've paid \$9,250 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services 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 Directory* www.amerhealthcaritasvipcare.com/pa to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.amerhealthcaritasvipcare.com/pa
- Call Member Services at 1-866-533-5490 (TTY users call 711) to get current provider information or to ask us to mail you a Provider 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 1-866-533-5490 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* www.amerihealthcaritasvipcare.com/pa to see which pharmacies are in our network. Here's how to get an updated Pharmacy Directory:

- Visit our website at www.amerihealthcaritasvipcare.com/pa
- Call Member Services at 1-866-533-5490 (TTY users call 711) to get current pharmacy information or to ask us to mail you a 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 1-866-533-5490 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Dental Services	You pay a \$0 copay. Preventive: The preventive dental benefits include the following services: • Oral exams – 1 every 6 months • Cleaning – 1 every 6 months	You pay a \$0 copay. Preventive: The preventive dental benefits include the following services: • Oral exams – 1 every 6 months • Cleaning – 1 every 6 months

- Fluoride treatment – 1 every 6 months
- Dental x-rays
 - o 6 radiograph codes per year. Full mouth series radiograph - 1 every 5 years.
 - o Panoramic radiograph 1 every 5 years.
 - o Cephalometric radiograph 1 every 5 years per member and does not count against 4 x-rays every year or 6 codes per year.

Comprehensive:

The combined total of comprehensive dental benefits cannot exceed \$6,000 every year.

The comprehensive dental benefits include the following services, up to a \$6,000 combined limit every year:

- Minor restorations (fillings)
- Simple extractions
- Dentures, 1 per arch every 5 years *
- Denture repair and reline, 1 per year *
- surgical extractions
- Oral surgery *
- Periodontics (1 per 24 months, per quadrant

- Fluoride treatment – 1 every 6 months
- Dental x-rays
 - o 1 full mouth radiograph and 1 panoramic radiograph every 5 years
 - o Up to 6 bitewing or periapical radiographs every year.

Comprehensive:

The combined total of comprehensive dental benefits cannot exceed \$5,750 every year.

- Restorative Services:
 - o Minor restorations (fillings).
 - o Prior authorization required
- Endodontics:
 - o 1 per tooth per lifetime.
 - o Pre and post-op radiographs required
 - o Prior authorization required
- Periodontics:
 - o Scaling and Root Planning - one per 24

Debridement once per year) *

- Endodontics (1 per tooth per lifetime) Pre and post-op radiographs required *
- Crowns, 1 every 5 years, per tooth. No more than 4 per calendar year, with no more than 2 crowns per arch *
- Mini-implants (lower arch only) and implant supported denture (lower arch only), 1 every 5 years *

*Prior authorization is required.

*Service limitations may apply Fixed bridges and all other dental implants, except for mini-implants are not covered.

We will only pay for covered dental services if you go to an in-network dentist.

In most cases, care you receive from an out-of-network provider will not be covered.

We will only pay for covered dental services if you go to an in-network dentist. In most cases, care you receive from an out-of-

months, per quadrant.

- o Debridement - 1 per year.
- o Scaling in the presence of gingival inflammation once per year.
- o Prior authorization required

- Prosthodontics, removal

- o Dentures – 1 per arch every 5 years.
- o Denture repair and reline, 1 per year.
- o Prior authorization required

- Maxillofacial prosthetics

- o 1 per arch every 5 years
- o Prior authorization required

- Implant services

- o Mini-implants (lower arch only) and implant supported denture (lower arch only), 1 every 5 years.

	network provider will not be covered.	- o Fixed bridges and all other dental implants except for mini-implants are not covered. - o Prior authorization required • Oral and Maxillofacial Surgery - o Crowns - 1 every 5 years, per tooth. No more than 4 per calendar year, with no more than 2 crowns per arch per year. - o Extractions - 1 per tooth per lifetime. - o Other oral surgery, limitations apply. - o Prior authorization required Subject to the \$5,750 combined limit every year.
Diabetic Supplies	You pay a \$0 copay.	You pay a \$0 copay.

(Part B)	Non-preferred brands will require an authorization. Preferred brands have a \$0 copay. Non-Preferred brands have a 20% coinsurance.	Non-preferred brands and all continuous glucose monitors will require a prior authorization and have a 20% co-insurance (until beneficiary reaches MOOP limit). Preferred brands have a \$0 copay.
Durable Medical Equipment (DME)	You pay a \$0 copay. Prior authorization is required for rental and purchased Medicare-covered prosthetics and medical supplies.	You pay a \$0 copay. Prior Authorization is required for: • Medicare-covered DME items over \$750 for purchase. • Rental and rent-to-purchase items. • The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item. • Enteral Nutritional Supplements.

Hearing Services	You pay a \$0 copay. This benefit includes: • 1 routine hearing exam every year. • Limited to 3 fittings/evaluation for hearing aids every 3 years. • Up to \$2,000 toward the cost of a non-implantable hearing aids from the applicable TruHearing® Choice catalog every 3 years. (limit 1 hearing aid per ear). After plan-paid benefit, you are responsible for the remaining costs. Each TruHearing-branded hearing aid purchase includes 1 year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following the purchase of a TruHearing branded hearing aid purchase while the member is enrolled in the plan. You must see a TruHearing provider to use this benefit. Hearing aid purchase includes:	You pay a \$0 copay. This benefit includes: • 11 routine hearing exam every year. • Unlimited fittings/evaluation for hearing aids. • Up to \$2,000 toward the cost of two non-implantable TruHearing branded Advanced hearing aids every 3 years (limit 1 hearing aid per ear). After plan-paid benefit, you are responsible for the remaining costs.* Each TruHearing-branded hearing aid purchase includes 1 year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following the purchase of a TruHearing branded hearing aid purchase while the member is enrolled in the plan. You must see a TruHearing provider to use this benefit.
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- First year of follow-up provider visits.
- 60-day trial period.
- 3-year extended warranty.
- 80 batteries per aid for non-rechargeable models.

Benefit does not include or cover any of the following:

- Over the counter (OTC) hearing aids.
- Ear molds.
- Hearing aid accessories.
- Additional provider visits.
- Additional batteries, batteries when a rechargeable hearing aid is purchased.
- Hearing aids that are not TruHearing-branded.
- Costs associated with loss & damage warranty claims

Costs associated with excluded items are the responsibility of the member and not covered by the plan.

Services not covered under any condition: Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), over the counter (OTC) hearing aids, ear

Hearing aid purchase includes:

- First 12 months of follow-up provider visits
- 60-day trial period
- 3-year extended warranty
- 80 batteries per aid for non-rechargeable models

Benefit does not include or cover any of the following:

- Over the counter (OTC) hearing aids
- Ear molds
- Hearing aid accessories
- Additional provider visits
- Additional batteries
- batteries when a rechargeable hearing aid is purchased
- Hearing aids that are not TruHearing-branded Advanced Aids
- Costs associated with loss & damage warranty claims

Costs associated with excluded items are the responsibility of the

molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).

member and not covered by the plan.

* Remaining costs refers to any amount in excess of your allowance

Over-the-Counter Items
(OTC)

You pay a \$0 copay.

Benefit includes \$320 for Medicare approved over-the-counter (OTC) items included in the OTC catalog, online ordering portal and/or qualified items at participating retail settings via a restricted spend debit card.

There is no limit on the total number of items or orders a member may purchase.

Any unused balance will automatically expire at the end of each month or upon disenrollment from the plan. Coverage includes Naloxone.

Members who qualify based on socioeconomic (LIS) status may use \$320 of the monthly allowance toward qualifying food & produce at participating retail locations and/or mail-order (item limits may apply) and/or qualifying rent and utility services, transportation, internet services, pest control, and pet supplies. Any unused balance will automatically expire at the end of each month or upon disenrollment from the plan.

You pay a \$0 copay.

Benefits include \$256 per month to spend on eligible OTC items such as vitamins, pain relievers, cold remedies, nicotine replacement therapy, and more.

Funds are loaded to a plan-issued debit card each month. Any unused funds will expire at the end of the month or upon disenrollment from the plan.

Naloxone is covered as a Part C OTC benefit. The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs

Members can shop through the OTC catalog or at participating retail stores.

No limit on the number of items or orders.

If you qualify, the OTC credit will be combined with the SSBCI credit.

Any unused funds will expire at the end of the month or upon disenrollment from the plan

	does not duplicate any Part D OTC or formulary drugs.
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Special Supplemental
Benefits for the
Chronically Ill (SSBCI)

Special Supplemental
Benefits for the Chronically
Ill (SSBCI) are not covered.

You pay a \$0 copay for
SSBCI benefits.

If you qualify for SSBCI,
you can apply the \$256
monthly OTC credit to
help with everyday
living expenses. This
credit can be used for:

- Healthy foods.
- General supports
for living (e.g., rent,
mortgage, utilities).
- Pest Control.
- Non-medical
transportation.

In order to qualify for
SSBCI, members must
have at least one of the
following chronic
health conditions:

- Cardiovascular
disorders,
- Chronic and
disabling mental
health conditions
- Chronic
gastrointestinal
disease (limited to
end stage liver
disease)
- Chronic lung
disorders (limited
to chronic
obstructive
pulmonary
disorder)
- Congestive heart
failure
- Connective tissue
disease

- Dementia
- Diabetes mellitus
- Overweight
- Obesity, & metabolic syndrome,
- Stroke.

In addition:

- The condition must be life threatening or greatly limit the overall health or function of the member
- The member must be at high risk of hospitalization or other adverse health outcomes
- The member must require intensive care coordination

The plan will review objective criteria to determine a member's eligibility. For more information or to check eligibility, members should contact the plan.

If a member qualifies, the SSBCI credit will be combined with the OTC credit. Unused amounts expire at the end of each month or upon disenrollment from the plan.

Substance Abuse (Individual and Group)	You pay a \$0 copay. Not all Outpatient Substance Abuse Services will require an authorization. Have your provider call the Plan to confirm if an authorization is required.	You pay a \$0 copay. Prior authorization may be required.
Transportation Services – Plan Approved Health-related Location	You pay a \$0 copay. 40 trips every year to plan-approved locations (e.g. doctor's office, pharmacy, and hospital). May consist of a car, shuttle, or van service depending on appropriateness for the situation and the member's needs. Rides must be scheduled at least 1 business day in advance except in special circumstances. Transportation is authorized for plan-approved locations only (e.g. doctor's office, pharmacy and hospital). Prior authorization is required for trips that exceed 50 miles for a one-way ride. Other prior authorization and scheduling rules apply.	You pay a \$0 copay. 36 one-way trips every year to plan-approved locations. May consist of a car, shuttle, or van service depending on appropriateness for the situation and the member's needs. Rides must be scheduled at least 1 business day in advance except in special circumstances. Transportation is authorized for plan-approved locations only (e.g. doctor's office, pharmacy and hospital). Limit of 50 miles per one-way trip.

Value-Based Insurance Design Model Benefit (VBID)	You pay a \$0 copay for VBID benefits. Members who qualify based on socioeconomic (LIS) status may use \$320 of the monthly allowance toward qualifying food & produce at participating retail locations and/or mail-order (item limits may apply) and/or qualifying rent and utility services, transportation internet services, pest control, and pet supplies. Any unused balance will automatically expire at the end of each month or upon disenrollment from the plan.	Value-Based Insurance Design Model Benefit (VBID) is not covered.
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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. You **can get the complete Drug List** by calling Member Services at 1-866-533-5490 (TTY users call 711) or visiting our website at www.amerihealthcaritasvipcare.com/pa

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 1-866-533-5490 (TTY users call 711) for more information.

Starting in 2026, we may immediately remove brand name drugs or original biological products on our Drug List if, we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we can decide to keep the brand name drug or original biological product on our Drug List but immediately move it to a different cost-sharing tier or add new restrictions or both.

For example: if you take a brand name drug or biological product that's being replaced by a generic or biosimilar version, you may not get notice of the change 30 days in advance, or before you get a month's supply of the brand name drug or biological product. You might get information on the specific change after the change is already made.

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: [www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients](https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients). You can also call Member Services at 1-866-533-5490 (TTY users call 711) or ask your health care provider, prescriber, or pharmacist 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 about your drug costs. If you get Extra Help and didn't get this material with this packet, and you don't get this material by October 1, 2025 call Member Services at 1-866-533-5490 (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 1 through Tier 5 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 total drug 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.

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Deductible: \$590	Deductible: \$615

Drug Costs in Stage 2: Initial Coverage

For drugs on tiers 1 through 5, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

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

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; 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)
Tier 1 – Preferred Generic	You pay a \$0 copay.	Standard cost sharing: You pay 25% of the total cost. Your cost for a 61 to 100-day mail-order prescription 25% coinsurance.
Tier 2 - Generic	You pay a \$0 copay.	Standard cost sharing: You pay 25% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier. Your cost for a 61 to 100-day mail-order prescription is 25% coinsurance.
Tier 3 – Preferred Brand	You pay a \$0 copay.	Standard cost sharing: You pay 25% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
		Your cost for a 61 to 100-day mail-order prescription is 25% coinsurance.
Tier 4–Non- Preferred Drug	You pay a \$0 copay.	Standard cost sharing: You pay 25% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier. Your cost for a 61 to 100-day mail-order prescription is 25% coinsurance.
Tier 5–Specialty	You pay a \$0 copay.	Standard cost sharing: You pay 25% of the total cost. Your cost for a 61 to 100-day mail-order prescription is 25% coinsurance.
Tier 6–Select Care Drugs	You pay a \$0 copay.	You pay \$0 of total cost.

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.

Changes to your VBID Part D Benefit

CMS announced the end of Value-Based Insurance Design, known as VBID after 2025. Many Medicare plans such as ours use VBID like a monthly credit to reduce the cost of prescription drugs and other supplemental benefits. Without VBID, we can no longer offer \$0 cost sharing for all prescription drugs in 2026.

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

SECTION 2 How to Change Plans

To stay in AmeriHealth Caritas VIP Care you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our AmeriHealth Caritas VIP Care.

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 AmeriHealth Caritas VIP Care
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from AmeriHealth Caritas VIP Care.
- **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 www.amerhealthcaritasvipcare.com/pa. Call Member Services at 1-866-533-5490 (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 3).
- **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 6), or call 1-800-MEDICARE (1-800-633-4227).

Section 2.1 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 separate Medicare

drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) between January 1 – March 31, 2026.

Section 2.2 Are there other times of the year to make a change?

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

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

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

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

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without separate 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 3 Get Help Paying for Prescription Drugs

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

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:

- o 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
- o Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778.
- o Your State Medicaid office.
- **Help from your state’s pharmaceutical assistance program (SPAP).** Pennsylvania has a program called PACE/PACENET that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **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 the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 1-866-533-5490 (TTY users call 711) or visit www.Medicare.gov.

SECTION 4 Questions?

Get Help from AmeriHealth Caritas VIP Care

- **Call Member Services at 1-866-533-5490. (TTY users call 711.)**

We’re available for phone calls October 1 – March 31: 8 a.m. - 8 p.m., seven days a week April 1 – September 30: 8 a.m. - 8 p.m., Monday through Friday. 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 AmeriHealth Caritas VIP Care. 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 www.amerihealthcaritasvipcare.com/pa or call Member Services at 1-866-533-5490 (TTY users call 711) to ask us to mail you a copy.

- **Visit** www.amerihealthcaritasvipcare.com/pa.

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 Pennsylvania the SHIP is called PA MEDI.

Call PA MEDI to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Call PA MEDI at 1-800-783-7067. Learn more about *PA MEDI* by visiting (<https://www.aging.pa.gov>)

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.

Get Help from Medicaid

Call Pennsylvania Medical Assistance (Medicaid), Pennsylvania Medical Assistance (Medicaid) at 1-800-692-7462. TTY users call 1-800-451-5886 for help with Medicaid enrollment or benefit questions.