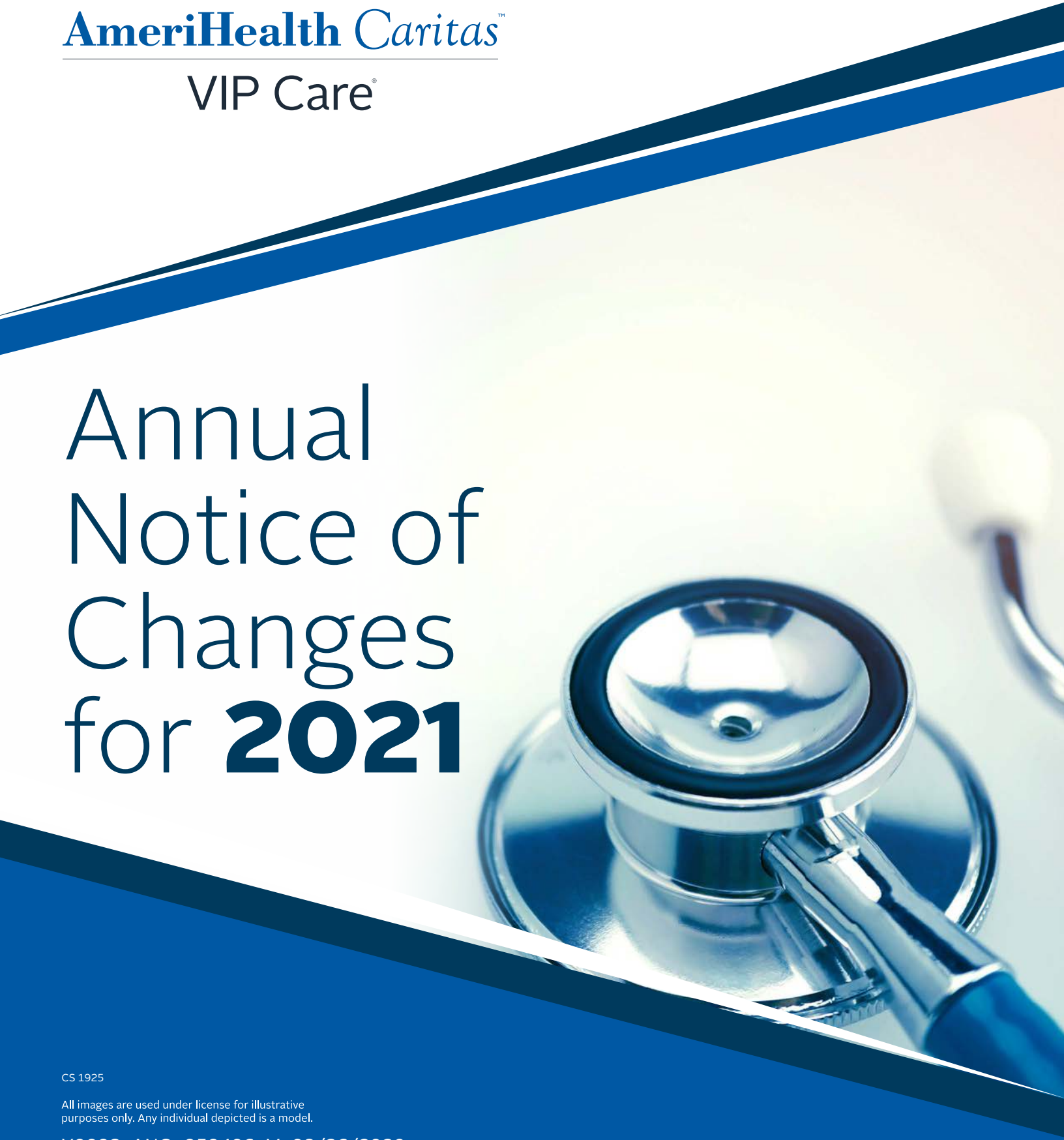
AmeriHealth Caritas™

VIP Care®

Annual Notice of Changes for **2021**



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OMB Approval 0938-1051 (Expires: December 31, 2021)

AmeriHealth Caritas VIP Care (HMO-SNP) offered by AmeriHealth First

Annual Notice of Changes for 2021

You are currently enrolled as a member of **AmeriHealth Caritas VIP Care**. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes*.

What to do now:

1. Ask: Which changes apply to you

☐ **Check the changes to our benefits and costs to see if they affect you.**

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1.5 for information about benefit and cost changes for our plan.

☐ **Check the changes in the booklet to our prescription drug coverage to see if they affect you.**

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit **https://go.medicare.gov/drugprices**. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ **Check to see if your doctors and other providers will be in our network next year.**

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Sections 1.3 and 1.4 for information about our Provider and Pharmacy Directory.

☐ **Think about your overall health care costs.**

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ **Think about whether you are happy with our plan.**

2. Compare: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at **www.medicare.gov** website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2 and 4.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. Choose: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in AmeriHealth Caritas VIP Care.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 3, page 12, to learn more about your choices.

4. Enroll: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you be enrolled in AmeriHealth Caritas VIP Care.
- If you join another plan between **October 15** and **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at **1-866-533-5490** for additional information. (TTY users should call **711**.) Hours are seven days a week, 8 a.m. – 8 p.m.
- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 6 of this booklet).
- Please contact Member Services if you require this document in an alternative format such as large font, Braille or audio.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

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. The plan also has a written agreement with the Pennsylvania Medicaid program to coordinate your Medicaid benefits.

- When this booklet says "we," "us," or "our," it means AmeriHealth First
  When it says "plan" or "our plan," it means AmeriHealth Caritas VIP Care.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for AmeriHealth Caritas VIP Care in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at **http://www.amerihealthcaritasvipcare.com/assets/pdf/member/eng/2021/snp-evidence-coverage.pdf**. You can also review the separately mailed Evidence of Coverage to see if other benefits or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage*. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit

Cost	2020 (this year)	2021 (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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$0 copay	$0 copay
Part D prescription drug coverage (See Section 1.6 or 2.6 for details.)	Deductible: $435 Copayment during the Initial Coverage Stage: **Drug Tier 1:** You pay $0, $1.30, or $3.60 per prescription. **Drug Tier 2:** You pay $0, $3.90, or $8.95 per prescription.	Deductible: $445 Copayment during the Initial Coverage Stage: **Drug Tier 1:** You pay $0, $1.30, or $3.70 per prescription. **Drug Tier 2:** You pay $0, $4.00, or $9.20 per prescription.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,400 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.	$3,400 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.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 — Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

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

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

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount **Because our members also get assistance 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 copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400 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.	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will 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

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at **www.amerihealthcaritasvipcare.com**. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 — Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may 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.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at **www.amerihealthcaritasvipcare.com**. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 — Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* only tells you about changes to your **Medicare** benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage*. A copy of the *Evidence of Coverage* is located on our website at **www.amerihealthcaritasvipcare.com**. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay	If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices

Cost	2020 (this year)	2021 (next year)
Continued: **Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay**	• Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *The majority of lab services do not require prior authorization. Some specialized lab services may require prior authorization.* *Certain services, such as physical, speech, and occupational therapy require prior authorization from the plan by your network provider.* *Prior authorization is required for Medicare-covered prosthetics and medical supplies over $500 for purchase. Authorization is required for all Medicare-covered prosthetics and medical supplies for rental.*	• Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *The majority of lab services do not require prior authorization. Some specialized lab services (for example, genetic testing lab services) may require prior authorization. Have your provider call AmeriHealth to confirm if an authorization is required.* *Certain services, such as physical, speech, and occupational therapy require prior authorization from the plan by your network provider.* *Prior authorization is required for Medicare-covered prosthetics and medical supplies over $500 for purchase. Authorization is required for all Medicare-covered prosthetics and medical supplies for rental.*

Cost	2020 (this year)	2021 (next year)
Acupuncture for chronic low back pain For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy.	Acupuncture **is not** covered.	Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. *Prior authorization is required for the Medicare-covered acupuncture benefit.*

Cost	2020 (this year)	2021 (next year)
Opioid Treatment Program Services	Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing *Referral required*	Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing *Prior authorization is required*

Cost	2020 (this year)	2021 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests *Prior authorization is required for outpatient blood services.*	Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests *Authorization is required.*

Cost	2020 (this year)	2021 (next year)
Continued: **Outpatient diagnostic tests and therapeutic services and supplies**	The majority of lab services do not require prior authorization. Some specialized lab services (for example, genetic testing lab services) may require prior authorization. Have your provider call AmeriHealth Caritas VIP Care to confirm if an authorization is required for your lab service. Not all outpatient diagnostic/therapeutic/ radiological and x-ray services will require authorization.	Not all outpatient diagnostic procedures, tests, and lab services will require authorization. The majority of lab services do not require prior authorization. Some specialized lab services (for example, genetic testing lab services) may require prior authorization. Have your provider call AmeriHealth Caritas VIP Care to confirm if an authorization is required. Not all outpatient diagnostic/therapeutic/ radiological and x-ray services will require authorization. The majority of x-ray services do not require prior authorization. *Authorization is required for some specialized x-ray services.* Have your provider call the Plan to confirm if an authorization is required.

Cost	2020 (this year)	2021 (next year)
Outpatient substance abuse services	• Medicare-covered individual therapy sessions • Medicare-covered group therapy sessions *No Authorization required*	• Medicare-covered individual therapy sessions • Medicare-covered group therapy sessions *Authorization is required.* Note: Not all Outpatient Substance Abuse services will require an authorization. Have your provider call the Plan to confirm if an authorization is required.
Transportation	Up to 80 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 24 hours in advance except in special circumstances. May consist of car, shuttle or van depending on the appropriateness for the situation and the member's needs. Transportation is authorized for plan-approved locations only (e.g., doctor's office, pharmacy and hospital).	Up to 100 one-way 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 one 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.*

Cost	2020 (this year)	2021 (next year)
OTC	Up to $150 per quarter may be spent for specific over-the-counter drugs. Monies not spent in a quarter do not roll over into the next quarter.	Up to $365 per quarter may be spent for specific over-the-counter drugs. Monies not spent in a quarter do not roll over into the next quarter.
Meal benefit, post-discharge	A maximum of 14 meals per week for 4 weeks for qualified homebound members after discharge from an inpatient facility or a skilled nursing facility. *Prior authorization required*	A maximum of 14 meals per week for 4 weeks for qualified homebound members after discharge from an inpatient facility or a skilled nursing facility. *Referral is required*
Meal benefit, COVID-19	This meal benefit only applies to affected enrollees during a public health emergency. Not included in documentation in 2020	The COVID-19 Meal Benefit allows for a maximum of 28 meals (28 meals is two week's worth of meals at 2 meals/day for 14 days) to any qualified member who is ordered to in home-isolation/quarantine or has tested positive to COVID-19 and in need of food services. This meal benefit only applies to affected enrollees during a public health emergency for COVID-19. *Referral is required.*

Cost	2020 (this year)	2021 (next year)
Gym Benefit	The benefit is for members to attend a health club or a fitness class at a plan-approved location. The benefit is limited to coverage of the membership fee. The goals of the benefit are to encourage a healthy lifestyle, to improve health status, and to help manage chronic conditions.	SilverSneakers® is a free fitness benefit which includes access to participating SilverSneakers® fitness facilities, online wellness resources, and classes.
Dental	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover the following services: • 1 cleaning every 6 months • 1 oral exam every 6 months • 1 fluoride treatment every 6 months • 1 dental x-ray every year	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover the following services: **Preventive:** • $1000 Plan coverage limit for preventive dental benefits every year • Oral exams – 1 every 6 months $0 copay • Cleaning – 1 every 6 months $0 copay • Fluoride treatment – 1 every 6 months $0 copay • Dental x-rays – 2 every year $0 copay

Cost	2020 (this year)	2021 (next year)
Continued: **Dental**	The comprehensive dental benefit covers minor restorations (fillings), simple extractions, dentures, denture repair, surgical extractions, oral surgery, periodontics, and endodontics up to a combined total of $2,000 every year. Crowns, bridges, and implants are not covered services. *Authorization is required for dentures, periodontics, and endodontics.*	**Comprehensive**: The combined total of comprehensive dental benefits cannot exceed $3,000 every year. The comprehensive dental benefits include the following services up to a $3000 combined limit every year: • minor restorations (fillings) • simple extractions • dentures, 1 every 5 years • denture repair and reline • surgical extractions • Oral surgery • Periodontics • Endodontics • 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). *Prior authorization is required.* Fixed bridges and all other dental implants except for mini-implants are not covered.

Cost	2020 (this year)	2021 (next year)
Continued: **Dental**		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.
Vision Care	Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year	Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year

Cost	2020 (this year)	2021 (next year)
Continued: **Vison Care**	• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Our plan offers supplemental vision coverage including: • Up to 1 routine eye exam every year • Up to 1 pair of eyeglasses (lenses and frames) every year Or - • Up to 1 pair of contact lenses every year $200 plan coverage limit for eye wear every year	• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Our plan offers supplemental vision coverage including: • $0 copay for Medicare-covered diagnosis and treatment for diseases and conditions of the eye • $0 copay for up to 1 routine vision exam every year • 1 pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • In addition to the cataract surgery benefit the plan will cover up to $350 every year towards eyeglasses or contact lenses

Cost	2020 (this year)	2021 (next year)
Continued **Vision Care**	The eyewear allowance only applies to the following limited eyewear benefits: Fashion / Designer / Premier frames collections; Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx); Tinting of Plastic Lenses; and Scratch-Resistant Coating. Or in lieu of eyeglasses, the $200 allowance may be applied to a limited selection of visually required contact lenses. Additional charges may apply for eyewear benefits that are not listed here.	The eyewear allowance only applies to the following limited eyewear benefits: Fashion / Designer / Premier frames collections; Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx); Tinting of Plastic Lenses; and Scratch-Resistant Coating. Or in lieu of eyeglasses, the $350 allowance may be applied to a limited selection of visually required contact lenses. Additional charges may apply for eyewear benefits that are not listed here. You must receive your care from a network provider. We will only pay for covered vision services if you go to an in-network vision provider. In most cases, you will have to pay for care that you receive from an out-of-network provider.

Cost	2020 (this year)	2021 (next year)
Hearing	Exam to diagnose and treat hearing and balance issues: routine hearing exam (for up to 1 every year) Hearing aid fitting/ evaluation for a hearing aid (for up to 1 every two years) Hearing aid: Our plan pays up to $1,000 every two years for hearing aids for both ears combined.	Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when furnished by a physician or other qualified provider. • $0 for up to 1 routine hearing exam every year • $0 for up to 3 fittings for a hearing aid every three years • $0 for 48 batteries per aid for non-rechargeable models every three years • $1,500 allowance for hearing aids every 3 years You must receive your care from a network provider. We will only pay for covered hearing services if you go to an in-network hearing provider. In most cases, you will have to pay for care that you receive from an out-of-network provider.

Cost	2020 (this year)	2021 (next year)
Telemedicine	Telemedicine is not covered.	MDLive offers all members 24/7 access throughout the year to a participating doctor via telephone, desktop, or mobile device. Members have the ability to immediately have a medical, counseling, or psychiatry consultation with a physician. Members can also schedule a telemedicine appointment for a later time. During the period of the COVID-19 public health emergency, the Plan will cover Medicare-covered telehealth services to affected enrollees in accordance with the relaxed Medicare standards that enable improved access to Medicare-covered telehealth services.

Section 1.6 — Changes to Part D Prescription 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, including changes to the 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 see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)) or call Member Services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you received a permission from us in 2020 to use a medication that is not on our formulary, known as a formulary exception, you can continue to use that medication in 2020 as long as your provider prescribes it for you. If you were prescribed a maintenance medication that had specific requirements that you met or were given permission from us to use in 2020, known as a coverage determination, you can continue to use this medication in 2021, as long as your provider prescribes it for you. However, if you received a coverage determination for a non-maintenance medication in 2020, and your provider prescribes it again in 2020, you or your provider will need to file a coverage determination request to determine if it is appropriate for you to use the medication in 2020. Your plan will notify you if any medications you are prescribed require you to make a new coverage determination request.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2, of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages — the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages — the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this Stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	Your deductible amount is either $0 or $435 depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $445, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage.*

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (*30 day*) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, at a network pharmacy that offers preferred cost-sharing, or for mail-order prescriptions, look in Chapter 6, Section 5, of your *Evidence of Coverage*. 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic (Tier 1):** You pay $0, $1.30, or $3.60 per prescription. **Brand (Tier 2):** You pay $0, $3.90, or $8.95 per prescription. Once you have paid $6,350 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic (Tier 1):** You pay $0, $1.30, or $3.70 per prescription. **Brand (Tier 2):** You pay $0, $4.00 or $9.20 per prescription. Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 2 Deciding Which Plan to Choose

Section 2.1 — If you want to stay in AmeriHealth Caritas VIP Care

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

Section 2.2 — If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- —*OR*— You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2021, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to **www.medicare.gov/plan-compare**. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans**.

Step 2: Change your coverage

- To change to **a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from AmeriHealth Caritas VIP Care.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from AmeriHealth Caritas VIP Care.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - —*or*— Contact **Medicare**, at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, seven days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from October 15 to December 7. The change will take effect on January 1, 2021.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling About Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called APPRISE.

APPRISE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. APPRISE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call APPRISE at **1-800-783-7067**. You can learn more about APPRISE by visiting their website at **https://www.aging.pa.gov**.

For questions about your Pennsylvania Medical Assistance benefits, contact The Office of Medical Assistance Programs (OMAP) at **1-800-692-7462** between 8:30 a.m. and 4:45 p.m. Monday – Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Pennsylvania Medical Assistance coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles, and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:

- **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
- The Social Security Office at **1-800-772-1213** between 7 am and 7 pm, Monday through Friday. TTY users should call, **1-800-325-0778** (applications); or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** 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 (the name and phone numbers for this organization are in Section 4 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Special Pharmaceutical Benefits Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

  Phone: **1-800-922-9384**

  Email: **spbp@pa.gov**

  Mail:

  PA Department of Health
  Special Pharmaceutical Benefits Program
  P.O. Box 8808
  Harrisburg, PA 17105-8808

  Fax: **1-888-656-0372**

SECTION 6 Questions?

Section 6.1 — Getting Help from AmeriHealth Caritas VIP Care

Questions? We're here to help. Please call Member Services at **1-866-533-5490**. (TTY only, call **711**). We are available for phone calls seven days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2021 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage* for AmeriHealth Caritas VIP Care. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is located on our website at **www.amerihealthcaritasvipcare.com**. You may also call Member Services to ask us to mail you an *Evidence of Coverage*. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Visit our website

You can also visit our website at **www.amerihealthcaritasvipcare.com**. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 — Getting Help from Medicare

To get information directly 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 should call **1-877-486-2048**.

Visit the Medicare Website

You can visit the Medicare website (**https://www.medicare.gov**). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to **https://www.medicare.gov/plan-compare).**

Read *Medicare & You 2021*

You can read the *Medicare & You 2021* 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. If you don't have a copy of this booklet, you can get it at the Medicare website (**https://www.medicare.gov**) or by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 6.3 — Getting Help from Medicaid

To get information from Pennsylvania Medical Assistance (Medicaid), you can call the Office of Medical Assistance at **1-800-692-7462**. TTY users should call **1-800-451-5886**.