AmeriHealth Caritas™

VIP Care®

AmeriHealth Caritas VIP Care (HMO-SNP)

2021 Summary of Benefits

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Summary of Benefits

January 1, 2021 - December 31, 2021

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage (EOC)" or visit us at **www.amerihealthcaritasvipcare.com**.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as AmeriHealth Caritas VIP Care (HMO-SNP).

Tips for comparing your Medicare choices

- This Summary of Benefits booklet gives you a summary of what AmeriHealth Caritas VIP Care covers and what you pay.
  - If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or you can use the Medicare Plan Finder on **www.medicare.gov**.
  - If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Sections in this booklet

- Things to Know About AmeriHealth Caritas VIP Care (HMO-SNP).
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.
- Extra (Supplemental) Benefits that AmeriHealth Caritas VIP Care covers.
- Medical Assistance (Medicaid) Benefits.
- Home and Community Based Services.

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. This information is not a complete description of benefits. Call **1-866-533-5490 (TTY 711)**, seven days a week, 8 a.m. – 8 p.m., for more information.

Out-of-network/non-contracted providers are under no obligation to treat AmeriHealth Caritas VIP Care members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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Things to Know About AmeriHealth Caritas VIP Care (HMO-SNP)

Hours of operation

- You can call us seven days a week from 8 a.m. to 8 p.m. Eastern time.

AmeriHealth Caritas VIP Care (HMO-SNP) phone numbers and website

- If you are a member of this plan, call toll free at **1-866-533-5490 (TTY 71**1).
- If you are not a member of this plan, call toll free at **1-855-241-3648 (TTY 71**1).
- Our website: **www.amerihealthcaritasvipcare.com**.

Who can join?

To join AmeriHealth Caritas VIP Care, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and the Pennsylvania Medical Assistance Program. You must qualify for Medical Assistance at one of the following categories of aid:

- Qualified Medicare Beneficiary Plus (QMB+).
- Specified Low-Income Medicare Beneficiary Plus (SLMB+).
- Full Benefit Dual Eligible (FBDE).

You must live in our service area. Our service area includes the following counties in Pennsylvania: **Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, and York**.

For prospective enrollees, if you have questions about your eligibility, call **1-855-241-3648 (TTY 711**).

Which doctors, hospitals, and pharmacies can I use?

- AmeriHealth Caritas VIP Care has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.
- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can view our plan's Provider and Pharmacy directories on our website, **www.amerihealthcaritasvipcare.com**.
- Or call us and we will send you a copy of the Provider and Pharmacy directories.

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What do we cover?

- **Like all Medicare health plans, we cover everything that Original Medicare covers — and more.**
  - ***Our plan members get all of the benefits covered by Original Medicare.***
  - ***Our plan members also get more than what is covered by Original Medicare.*** Some of the extra benefits are outlined in this booklet.
- We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.
  - You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **www.amerihealthcaritasvipcare.com**.
  - Or call us and we'll send you a copy of the formulary.

How will I determine my drug costs?

- Our plan groups each medication into one of two "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached.
- If you are in a program that helps pay for your drugs ("Extra Help"), you should receive a separate insert called the "Low Income Subsidy Rider" or LIS Rider, which tells you about your drug costs.

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Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

Questions about the costs	AmeriHealth Caritas VIP Care
How much is the monthly premium?	$0 per month.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you may pay nothing for Medicare-covered services, depending on your level of Pennsylvania Medical Assistance Program eligibility. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year. Refer to the **"Medicare & You"** handbook for Medicare-covered services. Please note that you will still need to pay your cost-sharing for your Part D prescription drugs..

Summary of Medical and Hospital Benefits That Are Covered by AmeriHealth Caritas VIP Care

The benefits described below in the left hand column are covered by AmeriHealth Caritas VIP Care. These are your Medicare covered benefits.

You pay $0 cost-sharing for your Medicare covered services with AmeriHealth Caritas VIP Care, because you receive Medicare cost-sharing assistance from the Pennsylvania Medical Assistance Program.

When you receive medical services, the provider should only bill AmeriHealth Caritas VIP Care for the cost of those services and cost-sharing amounts. The provider should not charge you for medical services or cost-sharing.

Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Inpatient Stay: Covered services received in a hospital or SNF during a non-covered inpatient stay	Our plan covers 90 days for an inpatient hospital stay. • Our plan also covers 60 "lifetime reserve days." These are "extra" days we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. 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 • 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.*	$0 copay

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Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Outpatient Hospital	Medically necessary services for diagnosis or treatment of an illness or injury: • X-rays. • Radiation therapy. • Surgical supplies. • Laboratory tests. • Outpatient diagnostic tests. *Not all outpatient preventative or diagnostic services will require authorization.*	$0 copay
Doctor's Office Visits	• Primary care physician visits. • Wellness visits. • Specialist care.	$0 copay
Preventive Care (continued on next page)	Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening. • Alcohol misuse counseling. • Bone mass measurement. • Breast cancer screening (mammogram). • Cardiovascular disease (behavioral therapy). • Cardiovascular screening. • Cervical and vaginal cancer screening. • Colorectal cancer screening (colonoscopy, fecal occult blood test, flexible sigmoidoscopy). • Depression screening. • Diabetes screening. • Diabetes self-management training. • Diabetic services and supplies. • Health and wellness education programs. • HIV screening. • Lung cancer screening. • Medical nutrition therapy. • Medicare Diabetes Prevention Program (MDPP).	$0 copay

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Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Preventive Care (continued)	• Obesity screening and counseling. • Prostate cancer screening (PSA). • Sexually transmitted infections screening and counseling. • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease). – Four additional face-to-face PCP visits for smoking/tobacco cessation annually. • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots. • Vision care. • "Welcome to Medicare" preventive visit (one time). • Yearly "Wellness" visit physical exam. Any additional preventive services approved by Medicare during the contract year will be covered.	$0 copay
Emergency Care	• Emergency room services provided by a qualified provider. • Ambulance services. Cost-sharing for necessary emergency services furnished out of network is the same as that for such services furnished in network. Our plan does not provide coverage for emergency medical care outside the United States and its territories.	$0 copay
Urgent Care	• Services needed to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Cost-sharing for necessary urgently needed services furnished out of network is the same as that for such services furnished in network. Our plan does not provide coverage for urgently needed care outside the United States and its territories.	$0 copay
Outpatient Diag Procs/ Tests Lab Services **Outpatient Diag/ Therapeutic Rad Services** (continued on next page)	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	$0 copay

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Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Outpatient Diag Procs/ Tests Lab Services **Outpatient Diag/ Therapeutic Rad Services**	*Authorization is required.* 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 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.	$0 copay
Hearing Services	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, audiologist, 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.*	$0 copay
Dental Services (continued on next page)	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	$0 copay

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Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Dental Services	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. *Prior authorization is required.* • 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 for dentures, periodontics, endodontics, crowns, mini implants, and implant supported dentures.* *Fixed bridges and all other dental implants except for mini-implants are not covered.*	$0 copay
Vision Services (continued on next page)	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 • 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.)	

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Summary of Benefits

Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Vision Services	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 • $350 plan coverage limit for eyewear every year *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.*	$0 Copay
Mental Health Services	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. • Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • Outpatient group therapy visit. • Outpatient individual therapy visit. *Prior authorization required for partial hospitalization services.*	$0 copay
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in an SNF. *Prior authorization required.*	$0 copay
Ambulance	Prior Authorization **is not** required for emergency ambulance services. Prior Authorization **is not** required for ambulance service between acute and sub-acute facilities. *Prior Authorization is required for all other ambulance services.*	$0 Copay

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Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Transportation	100 one-way trip(s) to authorized plan-approved locations every year (e.g., doctor's office, pharmacy, and hospital). May consist of car, shuttle, or van depending on the 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.*	$0 copay
Medicare Part B Drugs	Medicare Part B covers a limited number of drugs such as injections a beneficiary receives in a doctor's office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like nebulizer or external infusion pump), and, under very limited circumstances, certain drugs a beneficiary receives in a hospital outpatient setting. *Prior authorization required.*	$0 copay
Acupuncture	The Plan covers acupuncture for chronic low back pain for a specified number of visits when reasonable and necessary for treatment of chronic low back pain. Authorization is required for the Medicare-covered acupuncture benefit.	$0 copay
Ambulatory Surgical Center	If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." *Authorization required*	$0 copay
Chiropractor Services	Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).	$0 copay
Durable Medical Equipment and Supplies	Durable medical equipment (wheelchairs, oxygen, etc.). *Authorization is required for Medicare-covered DME items over $500 for purchase. Authorization is required for all Medicare-covered rental items.*	$0 copay
Federally Qualified Health Center/ Rural Health Clinic	AmeriHealth Caritas VIP Care has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.	$0 copay for in-network clinics

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Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Home Health Care	Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit; your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week). • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies. *Prior authorization required.*	$0 copay
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	$0 copay
Meal Benefit, COVID-19	**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.***	$0 copay
Meal Benefit, post-discharge	The post-discharge meal benefit covers 14 meals/week for 4 weeks for qualified homebound members after discharge from an inpatient facility or a skilled nursing facility. *Referral is required*	$0 copay
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 Authorization is required.	$0 copay
Outpatient Rehabilitation	• Cardiac (heart) rehab services. • Occupational therapy visit. • Physical therapy and speech and language therapy visit. *Prior authorization required.*	$0 copay

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Benefits	What AmeriHealth Caritas VIP Care covers (Medicare-covered services)	Your cost
Outpatient Substance Abuse	• 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.*	$0 copay
Podiatrist Services (foot care)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	$0 copay
Prosthetic Devices and Related Supplies	Devices (other than dental) that replace all or part of a body part or function. This may include, but is not limited to, braces, artificial limbs, pacemakers, colostomy care, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices, as well as coverage following cataract removal or cataract surgery. *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.*	$0 copay
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	$0 copay
Services to Treat Kidney Disease and Conditions	• Kidney disease education services. • Outpatient and inpatient dialysis treatment (including dialysis treatments when temporarily out of the service area). • Self-dialysis training. • Home dialysis training with certain home support services. • Certain drugs for dialysis are covered under your Medicare Part B benefit.	$0 copay
Telemedicine	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 COVID-19 pandemic emergency declaration period, 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.	$0 copay

AmeriHealth Caritas VIP Care Copays for Medicare Part D Prescription Drugs

Standard Retail Cost-Sharing

Tier	**One-month supply, two-month supply, and three-month supply** (If you reach the catastrophic coverage stage*, then you pay $0 copay for all tiers.)
Tier 1 (Generic)	$0, $1.30, or $3.70 per prescription.
Tier 2 (Brand)	$0, $4.00, or $9.20 per prescription.

Standard Mail-Order Cost-Sharing

Tier	**Three-month supply** (If you reach the catastrophic coverage stage*, then you pay $0 copay for all tiers.)
Tier 1 (Generic)	$0, $1.30, or $3.70 per prescription.
Tier 2 (Brand)	$0, $4.00, or $9.20 per prescription.

*Catastrophic Coverage

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. When you (or those paying on your behalf) have spent a total of $6,550 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage. You pay nothing.

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Extra (Supplemental) Benefits that AmeriHealth Caritas VIP Care covers

For each benefit listed below, you can see what AmeriHealth Caritas VIP Care covers in addition to Original Medicare covered benefits.

Benefit	AmeriHealth Caritas VIP Care	Your cost
Additional Smoking and Tobacco Use Cessation	Four additional face-to-face PCP visits for smoking/tobacco cessation annually.	**$0 copay**
Gym Benefit	SilverSneakers® is a free fitness benefit which includes access to participating SilverSneakers fitness facilities, online wellness resources, and classes.	**$0 copay**
Meal Benefit, COVID-19	**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.*	**$0 copay**
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. *Referral is required*	**$0 copay**
Non-Emergency Medical Transportation	$0 for up to 100 one-way trip(s) to plan-approved locations every year. Transportation is authorized for plan-approved locations only (e.g., doctor's office, pharmacy, and hospital). May consist of car, shuttle, or van depending on the 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.	**$0 copay**
Nurse Call Line	The Nurse Call Line is a service available to all members 24 hours a day, 7 days a week. The service is designed to provide members with a resource to answer health-related questions and to recommend the appropriate level of care.	**$0 copay**
Over the Counter Items (OTC)	Please visit our website to see our list of covered over-the-counter items. Up to $365 per quarter may be spent for OTC. Monies not spent in a quarter do not roll over into the next quarter.	**$0 copay**

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Benefit	AmeriHealth Caritas VIP Care	Your cost
Routine 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: **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 **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 $3,000 combined limit every year: • Minor restorations (fillings) • Simple extractions • Dentures, 1 every 5 years. Prior authorization required. • 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 for dentures, periodontics, endodontics, crowns, mini implants, and implant supported dentures.* *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.*	**$0 copay**

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Summary of Benefits

Benefit	AmeriHealth Caritas VIP Care	Your cost
Routine Hearing	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, audiologist, 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..*	**$0 copay**
Routine Vision Services	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 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 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.	**$0 copay**

Summary of Medical and Hospital Benefits That Are Covered by PA Medical Assistance

For each benefit listed below, you can see what Pennsylvania Medical Assistance covers.

Benefits	What PA Medical Assistance covers (Medicaid-covered services)
Ambulance	No limits
Chiropractor Services	No limits
Dental Services	• One set of dentures per lifetime. • One exam or prophylaxis every 180 days. • Diagnostic, preventive, restorative, surgical dental procedures; prosthodontics; and sedation. • Crowns, periodontics, and endodontics only via approved benefit limit exception.
Diagnostic Tests, Lab and Radiology Services, and X-Rays	No limits
Doctor's Office Visits	No limits
Emergency Care	No limits
Family Planning Clinic, Services, and Supplies	Family planning clinic, services, and supplies, no limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Services. Dental Services limits are described on page 11 of this document.
Hearing Services	Not covered
Home Health Care	Includes nursing aide and therapy services. Unlimited for first 28 days; limited to 15 days every month thereafter.
Hospice	Key limitation is related to respite care, which may not exceed a total of five days in a 60-day certification period.
Independent Clinic, Outpatient Hospital Clinic	No limits
Inpatient Hospital	• Inpatient acute hospital, no limits. • Inpatient rehab hospital, no limits. • Inpatient psychiatric hospital, no limits. • Inpatient drug and alcohol, no limits.

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Summary of Benefits

Benefits	What PA Medical Assistance covers (Medicaid-covered services)
Intermediate Care Facility for Individuals With Intellectual Disabilities (ICF/IID) and Intermediate Care Facility for Other Related Conditions (ICF/ORC)	Requires an institutional level of care. No limits. Not covered by Medicare.
Maternity and Newborn	Maternity — physician, certified nurse midwives, birth centers, no limits
Medical Equipment and Supplies	No limits
Medicare Part B Drugs	No limits
Mental Health Services	• Outpatient psychiatric clinic, no limits. • Mobile mental health treatment, no limits. • Outpatient drug and alcohol treatment, no limits. • Methadone maintenance, no limits. • Clozapine, no limits. • Psychiatric partial hospital, no limits. • Peer support, no limits. • Crisis, no limits. • Targeted case management — other than behavioral health, no limits. • Targeted case management —behavioral health only, limited to individuals with serious mental illness (SMI) only, no limits
Outpatient Hospital	• Outpatient ambulatory surgical center (ASC), no limits. • Outpatient hospital short procedure unit (SPU), no limits.
Outpatient Rehabilitation	Therapy (physical, occupational, speech) — rehabilitative: only when provided by a hospital, outpatient clinic, or home health provider. Therapy (physical, occupational, speech) — habilitative: only when provided by a hospital, outpatient clinic, or home health provider
Podiatrist Services (foot care)	No limits
Preventive Care	Tobacco cessation, 70 visits per calendar year
Prosthetic Devices and Related Supplies	• Orthopedic shoes and hearing aids are not covered. • Coverage for low vision aids is limited to one per two calendar years. • Coverage for an eye ocular is limited to one per calendar year.

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Summary of Benefits

Benefits	What PA Medical Assistance covers (Medicaid-covered services)
Services to Treat Kidney Disease and Conditions	Initial training for home dialysis is limited to 24 sessions per patient per calendar year.
Skilled Nursing Facility (SNF)	365 days per calendar year
Transportation	Only to and from Medicaid-covered services
Urgent Care	No limits
Vision Services	• Optometrist services: two vision exams per year • Eyeglass lenses limited to individuals with aphakia: four lenses per calendar year. • Eyeglass frames limited to individuals with aphakia: two frames per calendar year. • Contact lenses limited to individuals with aphakia: four lenses per calendar year.

Home- and Community-Based Services (HCBS) Covered Under Pennsylvania Medical Assistance

The following pages list the Home- and Community-Based Services (HCBS) Waiver Services covered by Pennsylvania Medical Assistance as well as any applicable benefit limits. HCBS Waiver Services allow for long-term care services in home- and community-based settings under the Medicaid program. There is no copayment for any of the services listed.

For all HCBS Waiver Services that are also offered under the state plan, the state plan benefit must be exhausted before HCBS Waiver Services can be accessed. Additionally, Medicare and other third-party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS Waiver Services may not be accessed at this time. HCBS services are available only to those who qualify to receive waiver service benefits.

Services covered under Pennsylvania Medical Assistance and HCBS Waiver Services

Home and Community-Based Services (HCBS)

Services	Limits
Adult Daily Living Services	Under Community Integration: Each distinct goal may not be more than 26 weeks. No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved. However, the Office of Long Term Living retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks.
Assistive Technology	
Behavior Therapy	
Benefits Counseling	
Career Assessment	
Cognitive Rehabilitation Therapy	
Community Integration	
Community Transition Services	
Counseling	

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Summary of Benefits

Services	Limits
Employment Skills Development	Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the state Medicaid agency program office. Total combined hours for employment skills development or job coaching services are limited to 50 in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval. Under Specialized Medical Equipment and Supplies, non-covered items include: • All prescription and over-the-counter medications, compounds, and solutions (except wipes and barrier cream). • Items covered under third-party payer liability. • Items that do not provide direct medical or remedial benefit to the participant and/or are not directly relatied to a participant's disability. • Food, food supplements, food substitutes (including formulas), and thickening agents. • Eyeglasses, frames, and lenses. • Dentures. • Any item labeled as experimental that has been denied by Medicare and/or Medicaid. • Recreational or exercise equipment and adaptive devices for such.
Home Adaptations	
Home Delivered Meals	
Home Health Aide	
Home Health — Nursing	
Home Health — Occupational Therapy	
Home Health — Physical Therapy	
Home Health — Speech and Language Therapy	
Job Coaching	
Job Finding	
Non-Medical Transportation	
Nutritional Counseling	
Participant-Directed Community Supports	
Participant-Directed Goods and Services	
Personal Assistance Services	
Personal Emergency Response System (PERS)	
Pest Eradication	
Residential Habilitation	
Respite	
Service Coordination	
Specialized Medical Equipment and Supplies	
Structured Day Habilitation	
TeleCare	
Vehicle Modifications	

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