OMB Approval 0938-1444 (Expires: June 30, 2026)

If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711), seven days a week, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.amerihealthcaritasvipcare.com/mi.

AmeriHealth Caritas VIP Care (HMO D-SNP) offered by AmeriHealth Caritas Michigan Inc.

Annual Notice of Change for 2026

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, rules, and costs. This *Annual Notice of Change* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at www.amerihealthcaritasvipcare.com/mi. Call Member Services at the number at the bottom of the page to get a copy by mail. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Additional resources

- This document is available for free in Arabic and Spanish.
- **You can get this Annual Notice of Change for free in other formats, such as large print, braille, or audio. Call 1-844-964-4433 (TTY 711).,**
- **8 a.m. to 8 p.m., seven days a week.**
- **After hours, on weekends, and on federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.**

You can request to get this document, now and in the future, in another format simply by calling Member Services at 1-888- 667-0318 (TTY 711), seven days a week, 8 a.m. to 8 p.m. We'll also ask for your preference during our Welcome call and later in the year, when you contact the plan. The plan will store your request and continue to send future documents in the requested format, unless you ask us to cancel or change the request. You can cancel or change your request at any time, simply by calling member Services. The calls are free.

Table of Contents

A. Disclaimers

AmeriHealth Caritas VIP Care is an HMO D-SNP plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to members. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal.

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

It's important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information on changes to your benefits for next year.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You'll still be in the Medicare and Michigan Medicaid programs as long as you're eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2** "Changing plans".
- Michigan Medicaid and options in **Section G2** "Changing plans".

B1. Information about AmeriHealth Caritas VIP Care

- AmeriHealth Caritas VIP Care (HMO D-SNP) is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members.
- When this *Annual Notice of Change* says "we," "us," "our," or "our plan," it means AmeriHealth Caritas VIP Care.

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they'll work for you next year.

  - Refer to **Section E1** for information about benefit and cost changes for our plan.

- **Check if there are any changes to our drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy or quantity limits?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** 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.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.]
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - How much will you spend out-of-pocket for the services and drugs you use regularly?
  - How do the total costs compare to other coverage options?
- **Think about whether you're happy with our plan.**

If you decide to stay with AmeriHealth Caritas VIP Care:	If you decide to change plans:
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in AmeriHealth Caritas VIP Care.	If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our plan name

On January 1, 2026, our plan name changes from AmeriHealth Caritas VIP Care Plus to AmeriHealth Caritas VIP Care.

You will get a new ID card in mail before January 1, 2026. Any plan materials you receive in the future will have the new plan name.

D. Changes to our network providers and pharmacies

Amounts you pay for your drugs depends on which pharmacy you use. Our plan has a network of pharmacies. In most cases, your prescriptions are covered *only* if they're filled at one of our network pharmacies*.:* Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our provider and*:* pharmacy networks have changed for 2026.

Please review the 2026 *Provider and Pharmacy Directory* to find out if your providers (primary care providers, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at www.amerihealthcaritasvipcare.com/mi . You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory.*

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook* or call Member Services at the number at the bottom of the page for help.

E. Changes to benefits and costs for next year

E1. Changes to benefits for medical services

We're changing our coverage for certain medical services next year. The table below describes these changes.

	2025 (this year)	2026 (next year)
Chiropractic Services	You pay a $0 copay. Covered services include: • Manual manipulation of the spine to correct subluxation	You pay a $0 copay. Covered service include: • Medicare-covered chiropractic care • 12 routine chiropractic visit per year

Dental Services	You pay a $0 copay.
	
	The plan pays for the following services:
	
	• Examinations and evaluations 1 every 6 months
	• Cleaning once every 6 months
	• Silver diamine fluoride treatment maximum of 6 applications per lifetime
	• X-rays
	  o Bitewing x-rays are a covered benefit only once in a 12-month period
	  o A panoramic x-ray once every 5 years
		You pay a $0 copay
		
		The plan pays for the following preventive dental services:
		
		• Oral exams 1 every 6 months.
		• 1 full mouth radiograph and 1 panoramic radiograph every 5 years and up to 6 bitewing or periapical radiographs every year.
		• Prophylaxis (cleaning) 1 every 6 months
		• Fluoride 1 every 6 months. Other preventative based on procedure.

	2025 (this year)	2026 (next year)
	o A full mouth or complete series of x-rays once every 5 years • Fillings • Tooth extractions • Complete or partial dentures once every five years • Sealants once every three years, if criteria are met • Indirect restorations (crowns) once every 5 years per tooth, if criteria are met • Root canal therapy/re-treatment of previous root canal • comprehensive periodontal evaluation • scaling in presence of inflammation • periodontal scaling and root planning • other periodontal maintenance We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation	The plan pays for the following comprehensive dental services: • Minor restorations (fillings). o Subject to the $5,000 combined limit every year. • Endodontics o Service limitations apply. o 1 per tooth per lifetime. o Pre and post-op radiographs required. o Prior authorization required. o Subject to the $5,000 combined limit every year. • Periodontics o Service limitations apply. o Prior authorization required. o Scaling and Root Planning - 1 per 24 mo. Per quadrant. o Debridement 1 per year. o Scaling in the presence of gingival inflammation 1 per year. o Subject to the $5,000 combined limit every year.

	2025 (this year)	2026 (next year)
	treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. *Prior authorization is required for restorative services, endodontics, periodontics, oral and maxillofacial surgery, removable and fixed prosthodontics.	o The combined total of the comprehensive dental benefits cannot exceed $5,000 every year: • 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 The combined total of the comprehensive dental benefits cannot exceed $5,000 every year: o 1 per arch every 5 years. o Prior authorization required. • Implant services o The combined total of the comprehensive dental benefits cannot exceed $5,000 every year: o Mini-implants (lower arch only) and implant supported denture (lower arch only), 1 every 5 years. o Fixed bridges and all other dental implants except for mini-implants are not covered.

	2025 (this year)	2026 (next year)
		o Prior authorization required. • Prosthodontics fixed o The combined total of the comprehensive dental benefits cannot exceed $5,000 every year: 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 Prior authorization required. • Oral and maxillofacial surgery. o The combined total of the comprehensive dental benefits cannot exceed $5,000 every year: o Extractions - 1 per tooth per lifetime. Other oral surgery, limitations apply. o Prior authorization required.
Durable Medical Equipment (DME)	You pay a $0 copay. The following items are covered: • Wheelchairs	You pay a $0 copay. Covered items include, but aren't limited to: • Wheelchairs,

	2025 (this year)	2026 (next year)
	• Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home Intravenous (IV) infusion pumps • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers • Breast pumps • Canes • Commodes • CPAP device • Enteral nutrition • Home uterine activity monitor • Incontinence supplies • Insulin pump and supplies • Lifts, slings and seats • Lymphedema pump • Negative pressure wound therapy • Orthopedic footwear • Orthotics • Osteogenesis stimulator • Ostomy supplies • Parenteral nutrition • Peak flow meter • Pressure gradient products	• Crutches, • Powered mattress systems, diabetic supplies, • Hospital beds ordered by a provider for use in the home, • IV infusion pumps, • Speech generating devices, • Oxygen equipment, • Nebulizers, and • Walkers The plan covers all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. 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)

	2025 (this year)	2026 (next year)
	• Pressure reducing support surfaces • Prosthetics • Pulse oximeter • Surgical dressings • Tracheostomy care supplies • Transcutaneous electrical nerve stimulator • Ventilators • Wearable cardioverter-defibrillators Other items may be covered. Some DME is provided based on Michigan Medicaid policy. Requirements for referral, physician order, and assessment apply along with limitations on replacement and repair. Other items may be covered, including environmental aids or assistive/adaptive technology. We may also cover you learning how to use, modify, or repair your item. Your Integrated Care Team will work with you to decide if these other items and services are right for you and will be in your Plan of Care.	regardless of cost per item • Enteral Nutritional Supplements Prior authorization is required for rental and purchased Medicare-covered prosthetics and medical supplies. Non-preferred brand of diabetic supplies and all continuous glucose monitors will require a prior authorization and will have a 20% co-insurance that will need to be billed to your Medicaid plan. Once you reach the MOOP limit, the copay will be $0. Preferred brands have a $0 copay.

	2025 (this year)	2026 (next year)
	Some items may also be covered through the Prepaid Inpatient Health Plan (PIHP) based on eligibility criteria. These items should be paid for by either our plan or the PIHP, not by both. We will pay for all medically necessary DME that Medicare and Michigan Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you. Prosthetics/Medical Supplies includes: • Rubber or vinyl gloves • Incontinence wipes • Reusable or disposable incontinence pads • Incontinence briefs in accordance with Michigan Medicaid policy Diapers and Pull-on briefs: For an enrollee using both diapers and pull-on briefs, the combined total quantity of these items cannot exceed 300 per month. (The maximum amount of pull-on briefs is 150 per month even	

	2025 (this year)	2026 (next year)
	if the enrollee is not using diapers.) Diapers of different sizes: For an enrollee using a combination of different sized diapers, the total quantity must not exceed 300 per month. Non-preferred brand Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts will require an authorization from the plan.	
Hearing Services	You pay a $0 copay. The plan pays for hearing and balance tests done by your provider. For adults aged 21 and older, the plan pays for evaluation and fitting for a hearing aid twice per year and pays for a hearing aid once every five years. Referral and authorization are required. The benefit is limited to TruHearing's Advanced hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. Hearing aid purchase includes:	You pay a $0 copay. The plan will cover: • Routine hearing exam (up to one every year) • Hearing aid fitting or evaluation Each TruHearing-branded hearing aid purchase includes one 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. Up to $2,500 toward the cost of two non-implantable TruHearing branded Advanced hearing aid(s)

	2025 (this year)	2026 (next year)
	• 2 Fitting/Evaluation for a Hearing aid every year • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Referral required for fitting/evaluation Referral required for fitting/evaluation. Referral and authorization are required. *Prior authorization required	every three years (limit one hearing aid per ear). After plan-paid benefit, you are responsible for the remaining costs.* You must see a TruHearing provider to use this benefit. 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 model is purchased 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

	2025 (this year)	2026 (next year)
		Costs associated with excluded items are the responsibility of the member and not covered by the plan. * Remaining costs refers to any amount in excess of your allowance.
Home and Bathroom Safety Devices and Modifications	Home and Bathroom Safety Devices and Modifications isn't covered.	You pay a $0 copay. $150 annual allowance for home and bathroom safety devices purchased through catalog and participating retail stores.
Intensive Outpatient Program Services	You pay a $0 copay.	You pay a $0 copay Prior Authorization is required.
Meal Benefit	Meal Benefit isn't covered.	You pay a $0 copay. The post-discharge meal benefit covers 14 meals over the course of one week for qualified homebound members after each discharge from an inpatient facility or a skilled nursing facility. Up to four times per year. Referral is required

	2025 (this year)	2026 (next year)
Medicare Part B Prescription Drugs	You pay a $0 copay.	You pay a $0 copay. • 0% coinsurance for preferred Part B drugs. • Non-preferred products will have a 20% co-insurance that needs to be billed to Medicaid. Once the Maximum Out-of-Pocket has been reached, the copay will be $0. • All insulin will not exceed $35 per 1 month supply.
Mental Health Specialty Services	You pay a $0 copay. The plan will pay for the following services, and maybe other: • Services not listed here • Clinic services • Day treatment • Psychosocial rehab services Prior authorization is required.	You pay $0 copay. • Medicare-covered Individual Sessions • Medicare-covered Group Sessions
Outpatient Blood Services	You pay a $0 copay.	You pay a $0 copay. Prior Authorization is required
Over-the-Counter (OTC) Items	You pay a $0 copay. Up to $75 per quarter may be spent for over-the-counter items included in the OTC catalog and/or ordering portal.	You pay a $0. Up to $80 per quarter to spend on eligible over-the-counter items such as vitamins, pain relievers, cold

	2025 (this year)	2026 (next year)
	Members may order up to six products per category per quarter. There is no limit on the number of total items in your order. OTC catalog and online portal orders are limited to three orders per quarter. Additional limits may apply to some items. Any unused balance will automatically expire at the end of each quarter or upon disenrollment from the plan. Coverage for Naloxone is included.	remedies, and more. Funds are loaded to a plan-issued debit card each month. • Members can shop through the OTC catalog or at participating retail stores • No limit on the number of items or orders Any unused funds will expire at the end of the quarter 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.
Personal Emergency Response System (PERS) isn't covered	Personal Emergency Response System (PERS) isn't covered	You pay a $0 copay. Personal Emergency Response System (PERS) is a medical alert monitoring system that provides 24/7 access to help at the push of a button. We offer multiple styles, including a mobile-enabled wearable device. Benefit limited to one device per year.

	2025 (this year)	2026 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI)	Special Supplemental Benefits for the Chronically Ill (SSBCI) are not covered.	You pay a $0 copay. If you qualify for SSBCI, you can apply the $80 quarterly OTC benefit credit to help with everyday living expenses. • Health foods. • General supports. for living (e.g., rent, mortgage utilities). • Pest control. 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:

	2025 (this year)	2026 (next year)
		• Your condition must be life threatening or greatly limit your overall health or function. • You must be at high risk of hospitalization or other adverse health outcomes and must require intensive care coordination. The plan will review objective criteria to determine your eligibility. For more information or to check eligibility, please contact the plan. If you qualify, the SSBCI credit will be combined with the OTC credit. Unused amounts expire at the end of each quarter or upon disenrollment from the plan.
Support for Caregivers of Enrollees	Support for Caregivers of Enrollees isn't covered.	You pay a $0 copay A member's caregiver can enroll in the support services through our plan-specified vendor. For more information, contact our Member Services Team.
Transportation Services	You pay a $0 copay.	You pay a $0 copay.

	2025 (this year)	2026 (next year)
	Unlimited round trip Non-Emergency Medical Transportation (NEMT) is covered. In cases where NEMT is only needed to get to an appointment or return home from an appointment, one-way authorization may be provided. Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, and attendants *Prior authorization is required for all non-emergency services.	Unlimited 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).
Vision Care	You pay a $0 copay. The plan pays for the following services: o Routine eye examinations once every two years. o An initial pair of eyeglasses. o Replacement glasses once every year. o Contact lenses for people with certain conditions.	You pay a $0 copay. The plan offers routine vision coverage including: • Routine eye exam once a year • Up to $520 every year toward to contact lenses or eyeglasses (lenses and frames) The benefit amount (allowance) must be used to pay for vision services from an in-network provider. In most cases, you will have to

	2025 (this year)	2026 (next year)
	o Basic and essential low vision aids (such as telescopes, microscopes, and certain other low vision aids). o Outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: o people with a family history of glaucoma, o people with diabetes, o African-Americans who are age 50 and older, and o Hispanic Americans who are 65 or older. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you	pay for care that you receive from an out-of-network provider.

	2025 (this year)	2026 (next year)
	did not get a pair of glasses after the first surgery.) *Prior authorization is required.	
Worldwide Emergency/Urgent Coverage	Worldwide Emergency/Urgent Coverage isn't covered	You pay a $0 copay. $50,000 (USD) combined annual maximum plan benefit amount for Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation

E2. Changes to drug coverage

Changes to our *Drug List*

An updated *List of Covered Drugs* is located on our website at www.amerihealthcaritasvipcare.com/mi. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a *List of Covered Drugs*.

The *List of Covered Drugs* is also called the *Drug List*.

We made changes to our *Drug List*, which could include removing or adding drugs, changing drugs we cover and changes to the restrictions that apply to our coverage for certain drugs 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 find out if there are any restrictions or if your drug has been moved to a different cost-sharing tier.

Most of the changes in the *Drug List* are new for the beginning of each year. However, we might make other changes are allowed by Medicare and/or the state that will affect you during the calendar year. We update our online *Drug List* at least monthly to provide the most up to date list of drugs. If we make a change that will affect a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
    - You can call Member Services at the numbers at the bottom of the page to ask for a *List of Covered Drugs* that treat the same condition.
    - This list can help your provider find a covered drug that might work for you.
- Ask us to cover a temporary supply of the drug.
    - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
    - This temporary supply is for up to 30 days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
    - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.

If you received permission from us in 2025 to use a drug that is not on our formulary, known as a formulary exception, in some instances you can continue to use that drug in 2026 as long as your doctor prescribes it for you. Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition. Non-maintenance drugs are those taken for a shorter period of time, for example antibiotics. If you were prescribed a maintenance drug that had specific requirements that you met or were given permission from us to use in 2025, known as a coverage determination, in some instances, you can continue to use this drug in 2026. However, if you received a coverage determination for a non-maintenance drug in 2025, you or your provider will need to again file a coverage determination request to continue using that drug in 2026. Starting in 2026, we can immediately remove brand name drugs or original biological products on our *Drug List* if, we replace them with new generics or certain biosimilars versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer rules. 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 rules 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, please go to **Chapter 12** of your *Member Handbook.* 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. You can also call Member Services at the number at the bottom of the page or ask your health care provider, prescriber, or pharmacist for more information.

Changes to drug costs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2026. You begin this stage after you pay a certain amount of out-of-pocket costs.

The Initial Coverage Stage ends when your total out-of-pocket costs for drugs reaches $2,100. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you'll pay for drugs.

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.

E3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, our plan pays a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

We moved some of the drugs on our *Drug List* to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our *Drug List*.

The following table shows your costs for a one-month supply filled at a network pharmacy with standard copays in each of our 7 drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

Most adult Part D vaccines are covered at no cost to you.

For 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, Section D** of your *Member Handbook*.

	2025 (this year)	2026 (next year)
Drugs in Tier 1 (Preferred Generic) Cost for a one-month supply of a drug in Tier 1that's filled at a network pharmacy	You pay a $0 copay.	Standard cost sharing: You pay 25% of the total cost. Your cost for a 61 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives **Deductible and coinsurance may apply for members without "Extra Help".

	2025 (this year)	2026 (next year)
Drugs in Tier 2 (Generic) Cost for a one-month supply of a drug in Tier 2 that's filled at a network pharmacy	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 - 100 days mail-order prescription is 25% coinsurance *Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without "Extra Help".
Drugs in Tier 3 **(**Preferred Brand) Cost for a one-month supply of a drug in Tier 3 that's filled at a network pharmacy	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 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without "Extra Help".

	2025 (this year)	2026 (next year)
Drugs in Tier 4 (Non-Preferred Drug) Cost for a one-month supply of a drug in Tier 4 that's filled at a network pharmacy	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 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without "Extra Help".
Drugs in Tier 5 (Specialty) Cost for a one-month supply of a drug in Tier 5 that's filled at a network pharmacy	You pay a $0 copay.	Standard cost sharing: You pay 25% of the total cost. Your cost for a 61 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives **Deductible and coinsurance may apply for members without "Extra Help".

	2025 (this year)	2026 (next year)
Drugs in Tier 6 (Select Care Drugs) Cost for a one-month supply of a drug in Tier 6 that's filled at a network pharmacy	You pay a $0 copay.	You pay $0 of the total cost.
Drugs in Tier 9 (Non-Medicare Rx/OTC Drugs)	You pay a $0 copay.	You pay $0 of the total cost.

E4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit **$2,100** for your drugs, the Catastrophic Coverage Stage begins and you pay nothing for your covered drugs. You stay in the Catastrophic Coverage Stage until the end of the calendar year. [

For more information about your costs in the Catastrophic Coverage stage, refer to **Chapter 6,** Section E, in your Member Handbook.

F. Administrative changes

Your MI Health Link plan AmeriHealth Caritas VIP Care Plus (Medicaid-Medicaid Plan) is changing. In 2026, you will be enrolled in AmeriHealth Caritas VIP Care (HMO D-SNP) for your Medicare and most of your Medicaid benefits. This plan is provided by AmeriHealth Caritas, which is the same company that currently provides your MI Health Link program coverage. Your new plan is part of the MI Coordinated Health program which will continue to coordinate your Medicare and Michigan Medicaid services and supports. You will still get the same health care benefits as you do now. Your new plan will help you with all your healthcare needs and will continue to coordinate your benefits and care.

	2025 (this year)	2026 (next year)
Contract Number	H0192	H6341
Organization Type	Demo	Local CCP
Plan Name	AmeriHealth Caritas VIP Care Plus (Medicare-Medicaid Plan)	AmeriHealth Caritas VIP Care (HMO D-SNP)
Plan Type	MMP HMO	HMO
Special Needs Plan Type	Not applicable	Dual-Eligible
Customer Service Phone Number	(888) 667-0318	(844) 964-4433
Pharmacy Customer Service Phone Number	(855) 328-0011	(855) 379-8895
Plan Web Site	www.amerihealthcaritasvipcareplus.com	www.amerihealthcaritasvipcare.com/mi
Medicare Prescription Payment Plan	Not applicable.	The Medicare Prescription Payment Plan may help you manage your drug costs by spreading them out during the year as monthly payments. To learn more about this program, please contact us at the number at the bottom of the page or visit www.medicare.gov/.

G. Choosing a plan

G1. Staying in our plan

We hope to keep you as a plan member. You don't have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you'll automatically stay enrolled as a member of our plan for 2026.

G2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you have Michigan Medicaid MICH plan, you can end your membership in our plan any month of the year.

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

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for <Medicaid program name> or Extra Help changed, **or**
- you recently moved into or are currently getting care in an institution (like a skilled nursing facility or a long-term care hospital). If you recently moved out of an institution, you can change plans or change to Original Medicare for two full months after the month you move out.

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section G2**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the MI Options Program*, 1-800-803-7174, office hours vary by location, open Monday through Friday (except holidays). TTY users may call 1-888-263-5897, 8:00 am to 7:00 pm EST, Monday through Friday (except holidays).* For more information or to find a local MI Options Program office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/long-term-services-and-supports. **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins. You can also contact the plan you wish to enroll in directly.

2. You can change to: **Original Medicare with a separate Medicare drug plan** **To apply for Medicaid, complete an application online at** www.michigan.gov/mibridges.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the MI Options Program, 1-800-803-7174, office hours vary by location, open Monday through Friday (except holidays). TTY users may call 1-888-263-5897, 8:00 am to 7:00 pm EST, Monday through Friday (except holidays).For more information or to find a local MI Options Program office in your area, please visit “https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/long-term-services-and-supports **OR** Enroll in a new Medicare drug plan. You’ll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare drug plan** **To apply for Medicaid, complete an application online at** www.michigan.gov/mibridges. **NOTE**: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the MI Options Program, 1-800-803-7174, office hours vary by location, open Monday through Friday (except holidays). TTY users may call 1-888-263-5897, 8:00 am to 7:00 pm EST, Monday through Friday (except holidays). For more information or to find a local MI Options Program office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/long-term-services-and-supports.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the MI Options Program, 1-800-803-7174, office hours vary by location, open Monday through Friday (except holidays). TTY users may call 1-888-263-5897, 8:00 am to 7:00 pm EST, Monday through Friday (except holidays).For more information or to find a local MI Options Program office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/long-term-services-and-supports. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. You can change to:	Here is what to do:
Any Medicare health plan during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: Call the at 1-800-803-7174. TTY users may call 1-888-263-5897 In Michigan, the SHIP is called the MI Options Program. **OR** Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins.

Your Michigan Medicaid services

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

H. Getting help

H1. Our plan

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Member Handbook*

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits and costs for 2026. It explains your rights and the rules to follow to get services and drugs we cover.

The *Member Handbook* for 2026 will be available by October 15. You can also review the Member Handbook to find out if other benefit or cost changes affect you. An up-to-date copy of the *Member Handbook* is available on our website at www.amerihealthcaritasvipcare.com/mi, You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2026.

Our website

You can visit our website at www.amerihealthcaritasvipcare.com/mi. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List* (*List of Covered Drugs*).

H2. MI Options

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

H3. The MICH Ombudsman

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

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

H4. Medicare

To get information directly from Medicare:

- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- chat live at www.Medicare.gov/talk-to-someone
- write to Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare's Website

You can visit the Medicare website (www.medicare.gov). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to www.medicare.gov and click on "Find plans.")

Medicare & You 2026

You can read the *Medicare & You 2026* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

H5. Michigan Medicaid

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

- Fee-for-service is the term for Medicaid paid services that aren't provided through a health plan. This means that Medicaid pays for the service. People under fee-for-service will use the MIhealth card to receive services.
- Additional information regarding MIhealth can be found by accessing the following website https://www.michigan.gov/mdhhs/assistance-programs/healthcare/adults/quicklinks/the-mihealth-card.
- Most people must join a health plan. The health plan pays for most of the services. For people that need to join a health plan, Michigan Enrolls will send a letter with more information. After enrollment with a health plan, both the MIhealth card and the health plan card are needed to access services. For additional information regarding joining a health plan, please visit the following website https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder14/Folder1/Folder114/MHP_Service_Area_Listing.pdf?rev=fe2f344f7c46481fb39eb034a8601cd5&hash=D59C718240AE79F1F708D4103AD823A8.

Costs

Enrollees don't have to pay the full cost of covered services; however, a small amount called a co-pay may be required. People age 21 and older may have a co-pay for the services listed in the Beneficiary Co-Payment Requirements. To see a list of co-pay amounts in this chart, please visit https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder60/WebCo-PayTable_11-02-06.pdf?rev=39dfeae1839e4434b66f503f84d63e45&hash=18CE85BF53B120E81739BD1F781CE2B8.

H6. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that may help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December) as monthly payments. This program doesn't save you money or lower your drug costs.

"Extra Help" from Medicare and help from your state's pharmaceutical assistance program (SPAP) and the AIDS Drug Assistance Program (ADAP), for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone. All enrollees are eligible to participate in this program, regardless of income level. To learn more about this program please contact us at the phone number at the bottom of this page or visit www.Medicare.gov.

H7. Additional Resources

The State of Michigan offers the myHealthButton and myHealthPortal tools for current members enrolled with the Michigan Medicaid program, Healthy Michigan Plan, MIChild and/or the Children's Special Health Care Services (CSHCS) program. The mobile application, myHealthButton is an online application that can be accessed from any device with internet access.

Members are encouraged to access the applications on a regular basis to take advantage of additional features.

Call	Beneficiary Help Line at 1-800-642-3195
TTY	1-866-501-5656
Email	myHealthButton@michigan.gov.
Website	https://myhbcld.state.mi.us/myHBPublic/landing.action?request_locale=en