

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

Annual Notice of Change for 2027

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, 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.amerhealthcaritasvipcare.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

- **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). We are available 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.**
- 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.

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

OMB Approval 0938-1444 (Expires: 5/31/2029)



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Table of Contents

A. Disclaimers	3
B. Reviewing your Medicare and Michigan Medicaid (Medicaid) coverage for next year	3
B1. Information about AmeriHealth Caritas VIP Care	3
B2. Important things to do	4
C. Changes to our network providers and pharmacies	5
D. Changes to benefits and costs for next year	6
D1. Changes to benefits for medical services	6
D2. Changes to drug coverage	12
D3. Stage 1: “Initial Coverage Stage”	14
D4. Stage 2: “Catastrophic Coverage Stage”	18
E. Choosing a plan	18
E1. Staying in our plan	18
E2. Changing plans	18
F. Getting help	22
F1. Our plan	22
F2. MI Options	23
F3. The MI Community, Home, and Health Ombudsman	23
F4. Medicare	23
F5. Michigan Medicaid	24
F6. The Medicare Prescription Payment Plan	25



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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 D** for more information on changes to your benefits for next year.

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

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

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

- Medicare options in the table in **Section - E2** "Changing plans".
- Michigan Medicaid options and services in **Section E2** "Changing plans".

B1. Information about AmeriHealth Caritas VIP Care

- AmeriHealth Caritas VIP Care is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members. Enrollment depends on contract renewal.
- When this *Annual Notice of Change* says "we," "us," "our," or "our plan," it means AmeriHealth Caritas VIP Care.



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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 D1** 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 D2** 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 C** for information about our *Provider and Pharmacy Directory*.



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- **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 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 to change plans:

If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section E2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our network providers and pharmacies

Amounts you pay for your drugs depend 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 provider and pharmacy networks have changed for 2027.

Please review the 2027 *Provider and Pharmacy Directory* to find out if your providers (primary care provider, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at www.amerhealthcaritasvipcare.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.



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D. Changes to benefits and costs for next year

D1. Changes to benefits for medical services

We're changing our coverage for certain medical services and what you pay for these covered medical services next year. The table below describes these changes.

	2026 (this year)	2027 (next year)
Dental Services	\$5,000 allowance every year. Maxillofacial Prosthetics: 1 per arch every 5 years. Prior authorization required. Removable prosthesis services not covered. Oral and Maxillofacial Surgery: Anesthesia not covered. Nitrous oxide not covered.	\$2,500 allowance every year. Maxillofacial Prosthetics: Not Covered We added coverage for services that allow a dentist to adjust your existing denture after dental mini-implant procedures, helping it fit properly without needing a new denture. Oral and Maxillofacial Surgery: Anesthesia covered under the following conditions: • Extractions of wisdom teeth; • 2 or more surgical extractions in 2 or more quadrants; • 4 or more surgical extractions in 1 quadrant; • Documentation of situational anxiety; • Documentation and narrative of medical necessity supported by submitted medical records (cardiac,



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	2026 (this year)	2027 (next year)
		cerebral palsy, epilepsy, or other condition that would render patient noncompliant). You may use nitrous oxide for certain covered dental services, including fillings, crowns, root canals, and extractions (not including Wisdom Teeth), and more. Prior authorization required.
Durable Medical Equipment (DME)	Prior Authorization is required for: • Medicare-covered DME items over \$750 for purchase. • Rental and rent-to-purchase items. • The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item • Enteral Nutritional Supplements	Prior authorization may be required for: • Medicare-covered DME items over \$750 for purchase. • Rental and rent-to-purchase items. Prior Authorization is required for: • The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item. • Enteral Nutritional Supplements.
Eyewear Services	There is \$520 allowance every year.	There is \$300 allowance every year.
Fitting Evaluation for Hearing Aid	Each TruHearing-branded hearing aid purchase includes one year of follow-up provider visits for fitting and	Each NationsHearing hearing aid purchase includes three [3] follow up visits for fitting and adjustments.



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	2026 (this year)	2027 (next year)
	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.	The three [3] visits are available to be used within one-year following the initial fitting date of a NationsHearing hearing aid purchase while the member is enrolled in the plan.
Hearing Aids (all types)	There is \$2,500 allowance every three years. The allowance covers the cost of two [2] non-implantable TruHearing branded Advanced hearing aid[s] every three [3] years (limit 1 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 models Benefit does not include or cover any of the following: • Over the counter (OTC) hearing aids • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries, batteries when a	\$0 copay The prescription hearing aid benefit includes up to two [2] hearings aids (1 aid per ear) every 3 years for Select hearing aid technology levels through NationsHearing at no cost to the member. All hearing aids offered through NationsHearing include: • 60-day evaluation period with a 100% money-back guarantee (no restocking fees) • 1 Hearing aid fitting per hearing aid • 3 follow-up appointments within one year of the fitting date • 3-year supply of batteries (for non-rechargeable hearing aids, up to 60 cells per ear, per year) • 3-year comprehensive manufacturer's warranty, including one time replacement for lost or damaged hearing aids



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	rechargeable hearing aid is purchased - Hearing aids that are not TruHearing-branded Advanced Aids - Costs associated with loss & damage warranty claims - Costs associated with excluded items are the responsibility of the member and not covered by the plan. * Remaining costs refers to any amount in excess of your allowance Services not covered under any condition: Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), over the counter (OTC) hearing aids, ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).	- Earmold(s) (first set, when needed) - Unlimited ongoing member support via NationsHearing
Home and Bathroom Safety Devices	There is \$150 annual allowance. Members will get the annual allowance added to their plan issued debit card to help with the cost of home and bathroom safety items. Approved items include: Grab bars or doorknobs,	Members may use the combined flexible spending debit card allowance of \$105 per quarter towards eligible home and bathroom safety devices such as grab bars or doorknobs, non-slip floor coverings, safety chairs, bathroom modification aids.



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	2026 (this year)	2027 (next year)
	• non-slip floor coverings, • safety chairs, • bathroom modification aids. Members can shop through the OTC catalog or at participating retail stores. Unused amounts expire at the end of each year or upon disenrollment from the plan.	Members can shop through the OTC catalog or at participating retail stores. Unused amounts expire at the end of each quarter or upon disenrollment from the plan.
Medicare Part B Drugs and Home Infusion Drugs	Step therapy not required	Part B step therapy may be required.
Over-the-Counter (OTC) Items	There is \$80 allowance every 3 months. OTC items include vitamins, pain relievers, cold 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.	Members may use the combined flexible spending debit card allowance of \$105 per quarter towards eligible OTC items. OTC items include vitamins, pain relievers, cold remedies, and more. Funds are loaded to a plan-issued debit card each quarter. • 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.
Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS) is a medical alert monitoring system that provides 24/7 access to help at the push of a	Not Covered



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	2026 (this year)	2027 (next year)
	button. We offer multiple styles, including a mobile-enabled wearable device. Benefit limited to one device per year.	
Podiatry Services-Routine Foot Care Non-Medicare	6 visits every year.	3 visits every year.
Special Supplemental Benefits for Chronically Ill (SSBCI)	There is \$80 allowance every 3 months.	Members may use the combined flexible spending debit card allowance of \$105 per quarter towards eligible SSBCI items. • Healthy Foods • Pest Control • General Supports for Living
Support for Caregivers of Enrollees	\$0 copayment for caregiver support services. A member's caregiver can enroll in the support services through our plan-specified vendor.	\$0 copayment for caregiver support services. A member's caregiver as well as members who are caregivers can enroll in the support services through our plan-specified vendor.
Transportation 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.	48 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



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	2026 (this year)	2027 (next year)
	Transportation is authorized for plan-approved locations only (e.g. doctor's office, pharmacy and hospital).	plan-approved locations only (e.g. doctor's office, pharmacy and hospital). Limit of 50 miles per one-way trip.

D2. Changes to drug coverage

Changes to our *Drug List*

Our *List of Covered Drugs* is also called the *Formulary* or *Drug List*. A copy of our *Drug List* is posted online at www.amerhealthcaritasvipcare.com/mi.

You can get the complete *Drug List* by calling Member services at the number at the bottom of the page or visiting our website at www.amerhealthcaritasvipcare.com/mi.

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

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

- Work with your doctor (or other prescriber) to find a different drug that we cover.
 - You can call Member Services at the numbers at the bottom of the page 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 180 days of the calendar year.



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- 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 2026 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 2027 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 2026, known as a coverage determination, in some instances, you can continue to use this drug in 2027. However, if you received a coverage determination for a non-maintenance drug in 2026, you or your provider will need to file a new coverage determination request to continue using that drug in 2027.

Starting in 2027, 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.

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.



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Changes to drug costs

Because you're eligible for Michigan's MI Health Link, you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We have sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider."

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay depends on your level of Extra Help and 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, 2027. 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 \$2,400. 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.

D3. 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*.



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The following table shows your costs for a one-month supply filled at a network pharmacy with standard copays in each of our 5 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 for a long-term supply; or for mail-order prescriptions go to **Chapter 6, Section D** of your *Member Handbook*.

	2026 (this year)	2027 (next year)
Drugs in Tier 1 (Preferred Generic) Cost for a one-month supply of a drug in Tier 1 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. one-month (30-day) mail-order prescription not offered.	Your copay for a one-month (30-day) supply is \$0. Your copay for a one-month (30-day) mail-order prescription is \$0.
Drugs in Tier 2 (Generic) Cost for a one-month supply of a drug in Tier 2 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. Your copay for a one-month (30-day) supply of each covered insulin product is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. one-month (30-day) mail-order prescription not offered.	Your copay for a one-month (30-day) supply is \$0, \$1.65, or \$4 for generic drugs. \$0 or \$4 for all other drugs. Insulin products not covered on this tier. Your copay for a one-month (30-day) mail-order prescription is \$0, \$1.65, or \$4 for generic drugs. \$0 or \$4 for all other drugs.



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	2026 (this year)	2027 (next year)
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	Your copay for a one-month (30-day) supply is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. Your copay for a one-month (30-day) supply of each covered insulin product is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. one-month (30-day) mail-order prescription not offered.	Your copay for a one-month (30-day) supply is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs. Your copay for a one-month (30-day) supply of each covered insulin product is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs. Your copay for a one-month (30-day) mail-order prescription is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs.
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	Your copay for a one-month (30-day) supply is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. Your copay for a one-month (30-day) supply of each covered insulin product is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. one-month (30-day) mail-order prescription not offered.	Your copay for a one-month (30-day) supply is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs. Your copay for a one-month (30-day) supply of each covered insulin product is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs. Your copay for a one-month (30-day) mail-order prescription is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs.



If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerihealthcaritasvipcare.com/mi.

	2026 (this year)	2027 (next year)
Drugs in Tier 5 (Specialty) Cost for a one-month supply of a drug in Tier 5 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0, \$1.60, or \$5.10 for generic drugs. \$0, \$4.90, or \$12.65 for all other drugs. Insulin products not covered on this tier. one-month (30-day) mail-order prescription not offered.	Your copay for a one-month (30-day) supply is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs. Your copay for a one-month (30-day) supply of each covered insulin product is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs. Your copay for a one-month (30-day) mail-order prescription is \$0, \$1.65, or \$5.80 for generic drugs. \$0, \$5, or \$14.40 for all other drugs.
Drugs in Tier 6 Cost for a one-month supply of a drug in Tier 6 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0.	Not applicable
Drug Tier 50: "Non-Part D drugs"	Not applicable	Your copay is \$0.

The Initial Coverage Stage ends when your total out-of-pocket costs reach **\$2,400**. At that point the Catastrophic Coverage Stage begins. The 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 about how much you pay for drugs.



If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerihealthcaritasvipcare.com/mi.

D4. Stage 2: “Catastrophic Coverage Stage”

When you reach the out-of-pocket limit **\$2,400** for your drugs, the Catastrophic Coverage Stage begins and you pay nothing for your covered Part D drugs. You stay in the Catastrophic Coverage Stage until the end of the calendar year. You may have copays for Medicaid covered drugs.

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

E. Choosing a plan

E1. Staying in our plan

We hope to keep you as a plan member. You don’t have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you’ll automatically stay enrolled as a member of our plan for 2027.

E2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you’re enrolled in AmeriHealth Caritas VIP Care (HMO D-SNP), you have some choices to end your membership in our plan including any month of the year.

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

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

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

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



If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerihelthcaritasvipcare.com/mi.

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section F2**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-inclusive Care for the Elderly (PACE) inquiries, call 1-855-483-7223. If you need help or more information: • Call MI Options at 1-800-803-7174. For more information or to find a local MI Options office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program. OR Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins. You can also contact the plan you wish to enroll in directly.
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If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerihealthcaritasvipcare.com/mi.

2. You can change to: Original Medicare with a separate Medicare drug plan To apply for Medicaid, complete an application online at www.michigan.gov/mibridges.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call MI Options at 1-800-803-7174 For more information or to find a local MI Options office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program . OR Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.
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If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerihealthcaritasvipcare.com/mi.

3. You can change to: Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason To apply for Medicaid, complete an application online at www.michigan.gov/mibridges. NOTE: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call MI Options at 1-800-803-7174. Office hours vary by location, open Monday through Friday (except holidays). TTY users may call 1-888-263-5897. Office hours are 8:00am to 7:00pm EST, Monday through Friday (except holidays). For more information please visit www.michigan.gov/MDHHSMIOptions.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call MI Options at 1-800-803-7174 For more information or to find a local office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.
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If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerihealthcaritasvipcare.com/mi.

4. You can change to: Any Medicare health plan during certain times of the year including the Open Enrollment Period and the Medicare Advantage Open Enrollment Period or other situations described in Section F2.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-483-7223. If you need help or more information: • Call MI Options at 1-800-803-7174 OR Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins.
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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.

F. Getting help

F1. 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 2027. It explains your rights and responsibilities and the rules to follow to get services and drugs we cover.



If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerhealthcaritasvipcare.com/mi.

The *Member Handbook for 2027* 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.amerhealthcaritasvipcare.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 2027.

Our website

You can visit our website at www.amerhealthcaritasvipcare.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)*.

F2. MI Options

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

F3. The MI Community, Home, and Health Ombudsman

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

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

F4. Medicare

To get information directly from Medicare:

- call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- chat live at www.Medicare.gov/talk-to-someone
- write to Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare's Website



If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerhealthcaritasvipcare.com/mi.

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

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

Medicare & You 2027

You can read the *Medicare & You 2027* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

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

F5. Michigan Medicaid

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

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

Costs

People with Medicaid and Medicare that are enrolled in a HIDE SNP, such as our plan, won't have premiums, co-pays, cost-sharing, coinsurance, or deductibles for in-network services,



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except in some instances for Medicare Part D drugs. Individuals with Pre-Eligibility Medical Expenses (PEME) and Patient Pay Amounts (PPAs) are still required to pay these expenses when enrolled in a HIDE SNP. If you disenroll from our HIDE SNP, you may have to pay a small amount called a co-pay. People age 21 and older may have a co-pay for the services listed in the Beneficiary Co-Payment Requirements. To see a list of co-pay amounts in this chart, please visit www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder60/WebCo-PayTable_11-02-06.pdf?rev=39dfeae1839e4434b66f503f84d63e45&hash=18CE85BF53B120E81739BD1F781CE2B8.

F6. 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. Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, you don't need to do anything to continue participating in 2027. This payment option might help you manage your expenses, but it doesn't save you money or lower your total out-of-pocket 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. To learn more about this program please contact us at the phone number at the bottom of this page or visit www.Medicare.gov.

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If you have questions, please call AmeriHealth Caritas VIP Care at 1-844-964-4433 (TTY 711). We are available 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. **For more information**, visit www.amerihealthcaritasvipcare.com/mi.