AmeriHealth Caritas VIP Care (HMO – SNP) offered by AmeriHealth Caritas VIP Next, Inc.

Annual Notice of Change for 2026

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

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

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in AmeriHealth Caritas VIP Care.
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your Medicare & You 2026 handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.amerihealthcaritasvipcare.com/de or call Member Services at **1-833-433-3767** (TTY users call **711**) to get a copy by mail.

More Resources

- Call Member Services at 1-833-433-3767 (TTY users call 711) for more information. Hours are October 1 – March 31: 8 a.m. - 8 p.m., seven days a week April 1 – September 30: 8 a.m. - 8 p.m., Monday through Friday. This call is free.
- Please contact Member Services if you require this document in an alternative format such as large font, Braille, or audio.

About AmeriHealth Caritas VIP Care

- AmeriHealth Caritas VIP Care is an HMO-SNP plan with a Medicare contract and a contract with the Delaware Medicaid program. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal. Our plan also has a written agreement with the Delaware Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means AmeriHealth Caritas VIP Next, Inc. When it says "plan" or "our plan," it means AmeriHealth Caritas VIP Care.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in AmeriHealth Caritas VIP Care.** Starting January 1, 2026, you'll get your medical and drug coverage through AmeriHealth Caritas VIP Care. Go to Section 2 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	$9,350 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$9,250 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	$0 per visit	$0 per visit
Specialist office visits	$0 per visit	$0 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a	$0 copay	$0 copay

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

	2025 (this year)	2026 (next year)
		Drug Tier 4 – Non-preferred drug: You pay 26% of the total cost. Except for covered insulin products and most adult Part D vaccines. You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 5 – Specialty: You pay 25% of the total cost. Drug Tier 6 – Select Care Drugs: You pay $0 of the total cost.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium unless it's paid for you by Medicaid.)	$0	$0

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

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

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$9,350	**$9,250** **Once you've paid $9,250 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* www.amerihealthcaritasvipcare.com/deto see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.amerihealthcaritasvipcare.com/de
- Call Member Services at 1-833-433-3767 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-833-433-3767 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage.*

Section 1.4 Changes to the Pharmacy Network

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

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

- Visit our website at www.amerihealthcaritasvipcare.com/de
- Call Member Services at 1-833-433-3767 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-833-433-3767 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

	2025 (this year)	**2026 (next year)**
Ambulatory Surgical Center (ASC) Services	You pay a $0 copay. Prior authorization required.	You pay a $0 copay. Prior authorization may be required for ambulatory surgical services.
Dental Services	You pay a $0 copay. **Preventive:**	You pay a $0 copay. **Preventive:**

	The preventive dental benefits include the following services:
	• Oral exams – 1 every 6 months
	• Cleaning – 1 every 6 months
	• Fluoride treatment – 1 every 6 months
	• Dental x-rays
	  ○ 6 radiograph codes per year. Full mouth series radiograph - 1 every 5 years.
	  ○ Panoramic radiograph 1 every 5 years.
	  ○ Cephalometric radiograph 1 every 5 years per member and does not count against 4 x-rays every year or 6 codes per year.
	Comprehensive:
	The combined total of comprehensive dental benefits cannot exceed $3,600 every year.
	The comprehensive dental benefits include the following services, up to a $3,600 combined limit every year:
	• Minor restorations (fillings)
		The preventive dental benefits include the following services:
		• Oral exams – 1 every 6 months
		• Cleaning – 1 every 6 months
		• Fluoride treatment – 1 every 6 months
		• Dental x-rays
		  ○ 1 full mouth radiograph and 1 panoramic radiograph every 5 years
		  ○ Up to 6 bitewing or periapical radiographs every year.
		Comprehensive:
		The combined total of comprehensive dental benefits cannot exceed $3,600 every year.
		• Restorative Services:
		  ○ Minor restorations (fillings).
		  ○ Prior authorization required
		• Endodontics:
		  ○ 1 per tooth per lifetime.
		  ○ Pre and post-op radiographs required

	• Simple extractions • Dentures, 1 per arch every 5 years * • Denture repair and reline, 1 per year * • surgical extractions • Oral surgery * • Periodontics (1 per 24 months, per quadrant Debridement once per year) * • Endodontics (1 per tooth per lifetime) Pre and post-op radiographs required * • Crowns, 1 every 5 years, per tooth. No more than 4 per calendar year, with no more than 2 crowns per arch * • Mini-implants (lower arch only) and implant supported denture (lower arch only), 1 every 5 years * *Prior authorization is required. *Service limitations may apply Fixed bridges and all other dental implants, except for mini-implants are not covered. We will only pay for covered dental services if you go to an in-network dentist.	○ Prior authorization required • Periodontics: ○ Scaling and Root Planning - one per 24 months, per quadrant. ○ Debridement - 1 per year. ○ Scaling in the presence of gingival inflammation once per year. ○ Prior authorization required • Prosthodontics, removal ○ Dentures – 1 per arch every 5 years. ○ Denture repair and reline, 1 per year. ○ Prior authorization required • Maxillofacial prosthetics ○ 1 per arch every 5 years ○ Prior authorization required • Implant services ○ Mini-implants (lower arch

	In most cases, care you receive from an out-of-network provider will not be covered. We will only pay for covered dental services if you go to an in-network dentist. In most cases, care you receive from an out-of-network provider will not be covered.	only) and implant supported denture (lower arch only), 1 every 5 years. ○ Fixed bridges and all other dental implants except for mini-implants are not covered. ○ Prior authorization required • Oral and Maxillofacial Surgery ○ Crowns - 1 every 5 years, per tooth. No more than 4 per calendar year, with no more than 2 crowns per arch per year. ○ Extractions - 1 per tooth per lifetime. ○ Other oral surgery, limitations apply. ○ Prior authorization required Subject to the $3,600 combined limit every year.

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

Over-the-Counter Items (OTC)	You pay a $0 copay. Benefit includes $225 per month for over-the-counter (OTC) items included in the OTC catalog, online ordering portal and/or qualified items at participating retail settings via a restricted spend debit card. There is no limit on the total number of items or orders a member may purchase. Any unused balance will automatically expire at the end of each month or upon disenrollment from the plan.	You pay a $0 copay. $85 per month to spend on eligible OTC items such as 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 • Unused amounts expire at the end of each month or upon disenrollment from the plan

Prescription Hearing Aids	You pay a $0 copay. Up to $1,500 toward the cost of a non-implantable hearing aid[s] from the applicable TruHearing Choice catalog every three year[s] (limit one hearing aid per ear). You must see a TruHearing provider to use this benefit. Hearing aid purchase includes: • First year of follow-up provider visits. • 60-day trial period. • three-year extended warranty. • 80 batteries per aid for non-rechargeable models. Benefit does not include or cover any of the following: • Over the counter (OTC) hearing aids. • Ear molds. • Hearing aid accessories. • Additional provider visits. • Additional batteries, batteries when a rechargeable hearing aid is purchased.	You pay a $0 copay. Up to $1,600 toward the cost of two non-implantable TruHearing branded Advanced hearing aid[s] every three years (limit one hearing aid per ear). 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. • three-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

	• Hearing aids that are not TruHearing-branded. After plan-paid benefit, you are responsible for the remaining costs. *	rechargeable hearing aid is purchased. • Hearing aids that are not TruHearing-branded Advanced Aids. After plan-paid benefit, you are responsible for the remaining costs. * 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.

Routine Hearing Exams	You pay a $0 copay. This benefit includes: • One routine hearing exam every year. • Limited to three fittings/evaluation for hearing aids every three years. You must receive your care from a network provider. We will only pay for covered hearing services if you go to an in-network hearing provider. In most cases, you will have to pay for care that you receive from an out-of-network provider.	You pay a $0 copay. This benefit includes: • One routine hearing exam every year. • Unlimited fittings/evaluation for hearing aids for 12 months. 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.
Substance Abuse (Individual and Group)	You pay a $0 copay. Not all Outpatient Substance Abuse services will require an authorization. Have your provider call the Plan to confirm if an authorization is required.	You pay a $0 copay. Prior authorization may be required.

Special Supplemental Benefits for the Chronically Ill (SSBCI)	Special Supplemental Benefits for the Chronically Ill (SSBCI) are not covered.	You pay a $0 copay for SSBCI benefits. If you qualify for the SSBCI benefit, you will receive a $104 monthly credit on a plan-issued debit card to help with everyday living expenses. This credit can be used for: • Health foods. • General supports. for living (e.g., rent, mortgage utilities). • Pest control. In order to qualify for SSBCI, you 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) • Chronis lung disorders (limited to chronic obstructive pulmonary disorder)

		• Congestive heart failure • Connective tissue disease • Dementia • Diabetes mellitus • Overweight, obesity, & metabolic syndrome • Stroke In addition: • You must be life threatening or greatly limit overall health or function of the member • You must be at high risk of hospitalization or other adverse health outcomes • You must require intensive care coordination The plan will review objective criteria to determine your eligibility. For more information or to check eligibility, you should contact the plan. Unused amounts expire at the end of each month or upon disenrollment from the plan.

		The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.
Transportation Services - Plan Approved Health-related Location	You pay a $0 copay. 40 trips every year to plan-approved locations (e.g. doctor's office, pharmacy, and hospital). May consist of a car, shuttle, or van service depending on appropriateness for the situation and your needs. Rides must be scheduled at least one business day in advance except in special circumstances. Transportation is authorized for plan-approved locations only (e.g. doctor's office, pharmacy and hospital). Prior authorization is required for trips that exceed 50 miles for a one-way ride. Other prior authorization and scheduling rules apply.	You pay a $0 copay. 28 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 your 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). Limit of 50 miles per one-way trip.

Value Based Insurance Design Model Benefit (VBID)	You pay a $0 copay for VBID benefits. Members who qualify based on socioeconomic (LIS) status may use $225 of the monthly allowance towards qualifying Food & Produce at participating retail locations and/or FarmBox mail-order, item limits may apply and/or qualifying rent, utility services, internet, pest control and pet supplies. Any unused balance will automatically expire at the end of each month or upon disenrollment from the plan.	(VBID) is not covered.

Vision Services	You pay a $0 copay. • One routine vision exam every year. The plan will cover up to $400 every year toward eyeglasses or contact lenses.	You pay a $0 copay. • One routine vision exam every year. The plan will cover up to $430 every year towards eyeglasses or contact lenses. The benefit amount (allowance) must be used to pay for vision services from an in-network provider. In most cases, you will have to pay for care that you receive from an out-of-network provider. You are responsible for amounts beyond the benefit limit’

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

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

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-833-433-3767 (TTY users call 711) for more information.

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

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

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You can also call Member Services at 1-833-433-3767 (TTY users call 711) or ask your health care provider, prescriber, or pharmacist for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs, which tells about your drug costs. If you get Extra Help and you don't get this material by October 1, 2025, call Member Services at 1-833-433-3767 (TTY users call 711) and ask for the LIS Rider.

Drug Payment Stages

There are 3 **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

You start in this payment stage each calendar year. During this stage, you pay the full cost of your tiers 1-5 drugs or until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

The table shows your cost per prescription during this stage.

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

Drug Costs in Stage 2: Initial Coverage

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

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

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	**2026 (next year)**
Tier 1- Preferred Generic:	You pay a $0 copay.	Standard cost sharing: You pay 25% of the total cost. Your cost for a 61 - 100 days mail-order prescription 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".
Tier 2 – Generic	You pay a $0 copay.	Standard cost sharing: You pay 25% of the total cost. You pay $*35* per month supply of each covered insulin product on this tier. 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.

	2025 (this year)	2026 (next year)
		*Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without “Extra Help.
Tier 3 – Preferred Brand	You pay a $0 copay.	Standard cost sharing: You pay 25% of the total cost You pay no more than $35 per month supply of each covered insulin product on this tier. Your cost for a 61- 100-day mail-order prescription 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”.
Tier 4-Non-Preferred Drug	You pay a $0 copay.	Standard cost sharing: You pay 26% 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-day mail-order

	2025 (this year)	2026 (next year)
		prescription is 26% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives **Deductible and coinsurance may apply for members without “Extra Help”.
Tier 5 – Specialty	You pay a $0 copay.	Standard cost sharing: You pay 25% of the total cost Your cost for a 60 or 100 day supply 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”.
Tier 6 - Select Care Drugs	You pay a $0 copay.	You $0 of the total cost.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.

Changes to your VBID Part D Benefit

As of 2026 CMS has discontinued Value Based Insurance Design (VBID) model for all Medicare Advantage Plans. We used VBID to lower cost sharing for our members with Extra Help to $0

for drugs in 2025. Starting 2026, depending on the level of Extra Help you receive, you may have to pay a co-pay/co-insurance for their drugs.

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

SECTION 2 How to Change Plans

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

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from AmeriHealth Caritas VIP Care.
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from AmeriHealth Caritas VIP Care.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll visit our website to disenroll online at www.amerihealthcaritasvipcare.com/de. Call Member Services at 1-833-433-3767 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty go to Section 3).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the Medicare & You 2026 handbook, call your State Health Insurance Assistance Program (go to Section 6), or call 1-800-MEDICARE (1-800-633-4227).

Section 2.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

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

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

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

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

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

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without separate Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 3 Get Help Paying for Prescription Drugs

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

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.

- Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778.
- Your State Medicaid office.

- **Help from your state's pharmaceutical assistance program (SPAP).** Delaware has a program called Delaware Prescription Assistance Program (DPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP) by calling 1-800-336-9500 or 1-800-MEDICARE.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 1-833-433-3767 (TTY users call 711) or visit www.Medicare.gov.

SECTION 4 Questions?

Get Help from AmeriHealth Caritas VIP Care

- **Call Member Services at 1-833-433-3767. (TTY users call 711.)**

  We're available for phone calls October 1 – March 31: 8 a.m. - 8 p.m., seven days a week April 1 – September 30: 8 a.m. - 8 p.m., Monday through Friday. Calls to these numbers are free.

- **Read your 2026 *Evidence of Coverage***

  This Annual Notice of Change gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for AmeriHealth Caritas VIP Care. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.amerihealthcaritasvipcare.com/deor call Member Services at *1*-833-433-3767 (TTY users call *711*) to ask us to mail you a copy.

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

  Our website has the most up-to-date information about our provider network (Provider Directory/Pharmacy Directory) and our List of Covered Drugs (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Delaware the SHIP is called Delaware Medicare Assistance Bureau.

Call Delaware Medicare Assistance Bureau to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Call Delaware Medicare Assistance Bureau at *1-800-336-9500*. Learn more about Delaware Medicare Assistance Bureau by visiting https://insurance.delaware.gov/divisions/dmab/.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

  You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with** www.Medicare.gov

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2026**

  The Medicare & You 2026 handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Get Help from Medicaid

Call Delaware Division of Medicaid & Medical Assistance Medicaid at 1-866-843-7212. TTY users call 1-800-955-8771 for help with Medicaid enrollment or benefit questions.