

## AmeriHealth Caritas VIP Care (HMO–SNP) offered by AmeriHealth Caritas Florida, 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](http://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/fl](http://www.amerihealthcaritasvipcare.com/fl) or call Member Services at 1-833-535-3767 (TTY users call 711) to get a copy by mail.

#### More Resources

- This document is available for free in Spanish and Creole.
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-535-3767 (TTY 711), de 8 a.m. a 8 p.m., los siete días de la semana. La llamada es gratuita.
- ATANSYON: Si w pale kreyòl, ou ka resevwa sèvis pou ede w nan lang pa w san w pa peye pou sa. Rele nan 1-833-535-3767 (TTY 711) lendi pou vandredi, soti 8 à nan maten rive 8 è diswa, ant 1ye avril ak 30 septanm, oswa sèt jou sou sèt, soti 8 è nan maten rive 8 è diswa, ant 1ye oktòb ak 31 mas. Apèl la gratis.
- Call Member Services at 1-833-535-3767 (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 Florida Medicaid program. Enrollment in AmeriHealth Caritas VIP

Care depends on contract renewal. Our plan also has a written agreement with the Florida Medicaid program to coordinate your Medicaid benefits.

- When this material says “we,” “us,” or “our,” it means AmeriHealth Caritas Florida 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)
<p><b>Monthly plan premium*</b></p> <p>* Your premium can be higher than this amount. Go to Section 1.1 for details.</p>	\$0	\$0
<p><b>Maximum out-of-pocket amount</b></p> <p>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)</p>	<p>\$9,350</p> <p>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.</p>	<p>\$9,250</p> <p>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.</p>
<b>Primary care office visits</b>	\$0 per visit	\$0 per visit
<b>Specialist office visits</b>	\$0 per visit	\$0 per visit
<p><b>Inpatient hospital stays</b></p> <p>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 doctor's order. The day before you're discharged is your last inpatient day.</p>	\$0 copay	\$0 copay

	<p style="text-align: center;"><b>2025 (this year)</b></p>	<p style="text-align: center;"><b>2026 (next year)</b></p>
<p><b>Part D drug coverage deductible</b> (Go to Section 1.6 for details.)</p>	<p>Deductible: \$590 except for insulin furnished through an item of durable medical equipment.</p>	<p>Deductible: \$615 except for covered insulin products and most adult Part D vaccines.</p>
<p><b>Part D drug coverage</b> (Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)</p>	<p>Copayment during the Initial Coverage Stage: You Pay \$0 per prescription.</p> <p>Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.</p>	<p>Drug Tier 1 – Preferred Generic: You pay 25% of the total cost.</p> <p>Drug Tier 2 –Generic: You pay 25% of the total cost.</p> <p>Except for covered insulin products and most adult Part D vaccines.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 3 – Preferred Brand: You pay 25% of the total cost.</p> <p>Except for covered insulin products and most adult Part D vaccines.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p>

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

## SECTION 1 Changes to Benefits & Costs for Next Year

### Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
<b>Monthly plan premium</b> (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)
<b>Maximum out-of-pocket amount</b> 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)	\$9,350	<b>\$9,250</b> <b>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.</b>

	2025 (this year)	2026 (next year)
<p>count toward your maximum out-of-pocket amount.</p> <p>Your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount.</p>		

### Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* [www.amerhealthcaritasvipcare.com/fl](http://www.amerhealthcaritasvipcare.com/fl) to 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.amerhealthcaritasvipcare.com/fl](http://www.amerhealthcaritasvipcare.com/fl). Call Member Services at 1-833-535-3767 (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 1-833-535-3767 (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.amerhealthcaritasvipcare.com/fl](http://www.amerhealthcaritasvipcare.com/fl) to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at [www.amerhealthcaritasvipcare.com/fl](http://www.amerhealthcaritasvipcare.com/fl).
- Call Member Services at 1-833-535-3767 (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 1-833-535-3767 (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.

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
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## Dental Services

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 – 4 every year
  - 6 radiograph codes per year per member.
  - Full mouth series - radiograph one every 5 years per member.
  - Panoramic radiograph -one every 5 years per member.
  - Cephalometric radiograph - one every 5 years per member and does not count against 4 x-rays every year or 6 codes per year.

**Comprehensive:**

The comprehensive dental benefits include the following services:

- Minor restorations (fillings).
- Simple extractions.

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 – 4 every year
  - 1 full mouth radiograph and 1 panoramic radiograph every 5 years
  - 6 bitewing or periapical radiographs every year.

**Comprehensive:**

You have a \$2,500 combined limit every year. Service limitation applies. The comprehensive dental benefits include the following services:

- Restorative Services:
  - Minor restorations (fillings).
  - Prior authorization required
- Endodontics
  - 1 per tooth per lifetime.

- Dentures, 1 per arch every 5 years\*
- Denture repair and reline\*
- Surgical extractions (limited to 1 per tooth, per lifetime)
- 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) \*

\*Prior authorization is required.

\*Service limitations may apply to comprehensive services.

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

- Pre-and post-op radiographs required.
- Prior authorization is required.
- Periodontics
  - Scaling and Root planning – 1 per 24 months per quadrant.
  - Debridement – once per year.
  - Scaling in the presence of gingival inflammation once per year.
  - Prior authorization is required.
- Prosthodontics, removable
  - Dentures – 1 per arch every 5 years.
  - Denture repair and reline – 1 per year.
  - Prior authorization is required.
- Maxillofacial prosthetics
  - 1 per arch every 5 years
  - Prior authorization is required.
- Implant services
  - Mini-implants (lower arch only)

	<p>dentist. In most cases, care you receive from an out-of-network provider will not be covered</p>	<p>and implant supported denture (lower arch only) - 1 every 5 years.</p> <ul style="list-style-type: none"> <li>○ Fixed bridges and all other dental implants except for mini-implants are not covered.</li> <li>○ Prior authorization is required.</li> <li>● Oral and Maxillofacial Surgery:             <ul style="list-style-type: none"> <li>○ Crowns - 1 every 5 years, per tooth. No more than 4 per calendar year, with no more than two crowns per arch per year.</li> <li>○ Extractions – 1 per tooth per lifetime.</li> <li>○ Other oral surgery, limitations apply.</li> <li>○ Prior authorization required.</li> </ul> </li> </ul>
<p>Diabetic Supplies (Part B)</p>	<p>You pay a \$0 copay.</p> <p>Non-preferred brands will require authorization.</p> <p>Preferred brands have a \$0 copay.</p>	<p>You pay a \$0 copay.</p> <p>Non-preferred brands and all continuous glucose monitors will require prior authorization and have</p>

	<p>Non-Preferred brands have a 20% coinsurance.</p>	<p>a 20% co-insurance (until beneficiary reaches MOOP limit).</p> <p>Preferred brands have a \$0 copay.</p>
<p>Durable Medical Equipment (DME)</p>	<p>You pay a \$0 copay.</p> <p>Prior authorization is required for rental and purchased Medicare-covered prosthetics and medical supplies.</p>	<p>You pay a \$0 copay.</p> <p>Prior Authorization is required for:</p> <ul style="list-style-type: none"> <li>• Medicare-covered DME items over \$750 for purchase.</li> <li>• Rental and rent-to-purchase items.</li> <li>• The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item.</li> <li>• Enteral Nutritional Supplements.</li> </ul>
<p>Over-the-Counter Items (OTC)</p>	<p>You pay a \$0 copay.</p> <p>Benefit includes \$225 per month may be spent on 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.</p> <p>There is no limit on the total number of items or</p>	<p>You pay a \$0 copay.</p> <p>Benefits include \$80 per month to spend on eligible OTC items such as vitamins, pain relievers, cold remedies, nicotine replacement therapy, and more.</p> <ul style="list-style-type: none"> <li>• Funds are loaded to a plan-issued debit card each month.</li> <li>• You can shop through the OTC</li> </ul>

orders a member may purchase.

Any unused balance will automatically expire at the end of each month or upon disenrollment from the plan.

Coverage includes Naloxone.

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 month or upon disenrollment from the plan.
- The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

Hearing Services

You pay a \$0 copay.

Hearing benefits include:

- 1 routine hearing exam every year.
- 1 fitting for a hearing aid (1 per ear), every year.
- Up to \$2,000 toward the cost of a non-implantable hearing aid[s] from the applicable TruHearing Choice catalog every 3 year[s] (limit 1 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
- 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

You pay a \$0 copay.

Hearing benefits include:

- 1 routine hearing exam every year.
- 12 months of follow up fittings/evaluation for hearing aid. Up to \$2,000 toward the cost of two non-implantable TruHearing branded Advanced hearing aid every 1 year (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:

- rechargeable hearing aid is purchased
- Hearing aids that are not TruHearing-branded
- Costs associated with loss & damage warranty claims
- Costs associated with excluded items are the responsibility of the member and not covered by the plan

After plan-paid benefit, you are responsible for the remaining costs.\*

- Over the counter (OTC) hearing aids
- Ear molds
- Hearing aid accessories
- Additional provider visits
- Additional batteries when a 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

		<ul style="list-style-type: none"> <li>• Ear molds hearing aid accessories warranty claim fees</li> <li>• Hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).</li> </ul>
<p>Special Supplemental Benefits for the Chronically Ill (SSBCI)</p>	<p>Special Supplemental Benefits for the Chronically Ill (SSBCI) are not covered</p>	<p>You pay a \$0 copay for SSBCI benefits.</p> <p>Members who qualify for SSBCI will receive a \$105 monthly credit on a plan-issued debit card to help with everyday living expenses. This credit can be used for:</p> <ul style="list-style-type: none"> <li>• Healthy foods</li> <li>• General supports for living (e.g., rent, mortgage, utilities)</li> </ul> <p>In order to qualify for SSBCI, members must have at least 1 of the following chronic health conditions:</p> <ul style="list-style-type: none"> <li>• Cardiovascular disorders</li> <li>• Chronic and disabling mental health conditions</li> <li>• Chronic gastrointestinal disease (limited to end stage liver disease)</li> <li>• Chronic lung disorders (limited to</li> </ul>

		<p>chronic obstructive pulmonary disorder)</p> <ul style="list-style-type: none"> <li>• Congestive heart failure</li> <li>• Connective tissue disease</li> <li>• Dementia</li> <li>• Diabetes mellitus</li> <li>• Overweight, obesity, &amp; metabolic syndrome</li> <li>• Stroke</li> </ul> <p>In addition:</p> <ul style="list-style-type: none"> <li>• The condition must be life threatening or greatly limit overall health or function</li> <li>• You must be at high risk of hospitalization or other adverse health outcomes</li> <li>• You must require intensive care coordination</li> </ul> <p>The plan will review objective criteria to determine your eligibility.</p> <p>For more information or to check eligibility, members should contact the plan.</p>
<p>Transportation Services</p>	<p>You pay a \$0 copay.</p>	<p>You pay a \$0 copay.</p>

	<p>Unlimited trips every year to plan-approved locations.</p> <p>Rides must be scheduled at least 1 business day in advance except in special circumstances.</p> <p>Prior authorization is required for trips that exceed 50 miles for a one-way ride. Other prior authorization and scheduling rules apply.</p>	<p>Unlimited one-way trips every year to plan-approved locations.</p> <p>Rides must be scheduled at least 1 business day in advance except in special circumstances.</p> <p>Transportation is authorized for plan-approved locations only (e.g. Doctor’s office, pharmacy and hospital).</p>
<p>Value-Based Insurance Design Model Benefit (VBID)</p>	<p>You pay a \$0 copay for VBID benefits.</p> <p>Members who qualify based on socioeconomic (LIS) status may use \$220 of the monthly allowance toward qualifying food &amp; produce at participating retail locations and/or mail-order (item limits may apply) and/or qualifying rent and utility services, transportation internet services, pest control, and pet supplies. Any unused balance will automatically expire at the end of each month or upon disenrollment from the plan.</p>	<p>Value-Based Insurance Design Model Benefit (VBID) is not covered.</p>

## 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 1-833-535-3767 (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](http://www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients). You can also call Member Services at 1-833-535-3767 (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 1-833-535-3767 (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 tier(s) 1-5 drugs 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)
<b>Yearly Deductible</b>	\$590 deductible	\$615 deductible

**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 is 25% coinsurance

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
Tier 2 – Generic	You pay \$0 copay.	<p>Standard cost sharing: You pay 25% of the total cost.</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Your cost for a 61 -100- days mail-order prescription is 25% coinsurance</p>
Tier 3 – Preferred Brand	You pay \$0 copay.	<p>Standard cost sharing: You pay 25% of the total cost</p> <p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Your cost for a 61- 100- day mail-order prescription is 25% coinsurance.</p>
Tier 4-Non-Preferred Drugs	You pay \$0 copay.	<p>Standard cost sharing: You pay 25% of the total cost</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p>

	2025 (this year)	2026 (next year)
		<p>You pay no more than \$35 per month supply of each covered insulin product on this tier.</p> <p>Your cost for a 61- 100-day mail-order prescription is 25% coinsurance.</p>
Tier 5 – Specialty	You pay \$0 copay.	<p>Standard cost sharing: You pay 25% of the total cost</p> <p>Your cost for a 61- 100-day mail-order prescription is 25% coinsurance.</p>
Tier 6 - Select Care Drugs	You pay \$0 copay.	You pay \$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 members receive, members 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

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**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.amerhealthcaritasvipcare.com/fl](http://www.amerhealthcaritasvipcare.com/fl) or call Member Services at 1-833-535-3767 (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](http://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 separate Medicare drug coverage) or switch to Original Medicare (with or without 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**

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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.

- **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 1-833-535-3767 (TTY users call 711) or visit [www.Medicare.gov](http://www.Medicare.gov).

## SECTION 4 Questions?

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### Get Help from AmeriHealth Caritas VIP Care

- **Call Member Services at 1-833-535-3767. (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/fl](http://www.amerihealthcaritasvipcare.com/fl) or call Member Services at 1-833-535-3767 (TTY users call 711) to ask us to mail you a copy.

- **Visit [www.amerihealthcaritasvipcare.com/fl](http://www.amerihealthcaritasvipcare.com/fl).**

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 Florida the SHIP is called SHINE (Serving Health Insurance Needs of Elders).

Call SHINE 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 SHINE at 1-800-96-ELDER (1-800-963-5337). Learn more about SHINE by visiting <http://www.floridashine.org/>

## 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](http://www.Medicare.gov)**

You can chat live at [www.Medicare.gov/talk-to-someone](http://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](http://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](http://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 Florida Medicaid at 1-888-419-3456. TTY users call 1-800-955-8711 for help with Medicaid enrollment or benefit questions.