2027 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

Look inside to learn more about this plan:

AmeriHealth Caritas VIP Care Choice (HMO D-SNP)

January 1, 2027 – December 31, 2027

H0738_002_128437_M_Accepted_09292026

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

This booklet provides you with a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage* (EOC) or visit us at www.amerihealthcaritasvipcare.com/de/choice.

You have choices about how to get your Medicare benefits

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

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **AmeriHealth Caritas VIP Care Choice (HMO D-SNP)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **AmeriHealth Caritas VIP Care Choice (HMO D-SNP)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in Spanish. For additional information, call us at 1-833-467-3302 (TTY users call 711).

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

Hours of Operation & Contact Information

- Call 1-833-467-3302 (TTY: 711), October 1 – March 31, 8 a.m. – 8 p.m., seven days a week. From April 1 – September 30, call 8 a.m. – 8 p.m., Monday through Friday. The call is free.
- **Not a member?** Call us at 1-800-447-2739, (TTY: 711), 8 a.m. – 8 p.m., Eastern Standard Time, 7 days a week (October 1 – March 31) and 8 a.m. – 8 p.m., Eastern Standard Time, Monday – Friday (April 1 – September 30). The call is free.
- Our website: www.amerihealthcaritasvipcare.com/de/choice.

Who can join AmeriHealth Caritas VIP Care Choice (HMO D-SNP)?

To join **AmeriHealth Caritas VIP Care Choice (HMO D-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and be enrolled in the Delaware Medical Assistance Program (Medicaid). You must qualify for Medical Assistance in one of the following categories of aid:

- Qualified Medicare Beneficiary **(QMB)**.
- Specified Low-Income Medicare Beneficiary **(SLMB)**.
- Qualifying Individual **(QI)**.
- Qualified Disabled & Working Individuals **(QDWI)**.

You must live in our service area. **Our service area includes these counties in Delaware: Kent, New Castle and Sussex.**

For prospective enrollees, if you have questions about your eligibility, call **1-800-447-2739, (TTY 711)**.

Which doctors, hospitals, and pharmacies can I use?

- AmeriHealth Caritas VIP Care Choice (HMO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers. You must receive your care from a network provider. We will only pay for covered services if you go to an in-network provider. In most cases, you will have to pay for care that you receive from an out-of-network provider. Out-of-network/non-contracted providers are under no obligation to treat AmeriHealth Caritas VIP Care Choice (HMO D-SNP) members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.
- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can view our plan's Provider and Pharmacy Directories on our website, www.amerihealthcaritasvipcare.com/de/choice.
- You can also call us, and we will send you a copy of the Provider and Pharmacy Directories.

What we cover

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

How will I determine my drug costs?

- Our plan groups all medications into one of five tiers. The cost of your drugs will depend on the level of "Extra Help" you receive and what tier they are in.

If you have any questions about this plan's benefits or costs, please contact AmeriHealth Caritas VIP Care Choice (HMO D-SNP)

2 SECTION II - SUMMARY OF BENEFITS

AmeriHealth Caritas VIP Care Choice (HMO D-SNP)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**AmeriHealth Caritas VIP Care Choice (HMO D-SNP)**
Monthly Plan Premium	You pay $0 for your plan premium. You must continue to pay your Medicare Part B premium.
Deductible	Prescription Drug Deductible: $120. Your plan does not have a medical deductible.
Maximum Out-of-Pocket Responsibility	In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid eligibility. Your yearly limit(s) in this plan: • **$9,250** for Medicare-covered services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**AmeriHealth Caritas VIP Care Choice (HMO D-SNP)**
Inpatient Hospital Coverage	$1,500 copay per stay* *Prior authorization is required.*
Outpatient Hospital Coverage	Outpatient hospital: 20% coinsurance* Outpatient Surgery: 20% coinsurance* *Not all outpatient preventive or diagnostic services will require prior authorization.*
Ambulatory Surgical Center (ASC) Services	Ambulatory Surgical Center: 20% coinsurance* *Prior authorization may be required.*
Doctor Visits (Primary Care Providers and Specialists)	Primary care provider (PCP) visit: $0 copay Annual Wellness visit: $0 copay Specialist visit: 20% coinsurance*
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	$0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$115 copay* Worldwide Emergency Coverage: $0 copay Annual maximum coverage amount of $50,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures. Cost-sharing for necessary emergency services furnished out of network is the same as that for such services furnished in-network.
Urgently Needed Services	$40 copay* Worldwide Urgent Coverage: $0 copay Annual maximum coverage amount of $50,000 applies for emergency services and urgent care visits outside the United States. This does not include planned procedures. This includes services needed to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Benefits/Services	AmeriHealth Caritas VIP Care Choice (HMO D-SNP)
Urgently Needed Services (continued)	Cost-sharing for necessary urgently needed services furnished out of network is the same as that for such services furnished in-network.
Diagnostic Services / Labs/Imaging (including diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	Covered services include, but are not limited to: Diagnostic tests and procedures: 20% coinsurance* Lab services: 20% coinsurance* Diagnostic Radiology Services (such as MRI, CAT Scan): 20% coinsurance* Outpatient X-rays: 20% coinsurance* Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance* *Not all outpatient diagnostic procedures, tests, and lab services will require prior authorization. The majority of lab services do not require prior authorization. Some specialized lab services (for example, genetic testing lab services) may require prior authorization. Have your provider call the Plan to confirm if prior authorization is required.*
Hearing Services	Exam to diagnose and treat hearing and balance issues: 20% coinsurance* Routine hearing exam (up to 1 visit(s) every year): $0 copay. The prescription hearing aid benefit includes up to two [2] hearings aids (1 aid per ear) every 3 years for Standard 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 • Earmold(s) (first set, when needed) • Unlimited ongoing member support via NationsHearing

Benefits/Services	AmeriHealth Caritas VIP Care Choice (HMO D-SNP)
Dental Services	Preventive dental services: • Oral exam (up to 1 visit every six months): $0 copay. • Cleaning (up to 1 visit every six months): $0 copay. • Fluoride treatment (up to 1 visit every six months): $0 copay. • Dental X-rays (1 full mouth radiograph and 1 panoramic radiograph every 5 years and up to 6 bitewing or periapical radiographs every year.): $0 copay. Comprehensive dental services: • Minor restorations (fillings). • Simple and Surgical extractions. • Dentures (1 per arch every 5 years). • Denture repair and reline. • Oral surgery. • Periodontics/endodontics. • Crowns. • Mini-implants. $1,250 plan coverage limit for comprehensive dental benefits every year. 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, 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. We added coverage for services that allow a dentist to adjust your existing denture after dental mini-implant procedures, helping it to fit properly without needing a new denture.

Benefits/Services	AmeriHealth Caritas VIP Care Choice (HMO D-SNP)
Dental Services (continued)	*Prior authorization required for comprehensive dental services. Additional limits may apply. You are responsible for amounts beyond the benefit limit.*
Vision Services	Routine eye exam (up to 1 visit every year): $0 copay. Eyewear after cataract surgery: 20% coinsurance* Contact lenses OR Eyeglasses: Our plan pays up to $100 every year for eyewear. *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 from an out-of-network provider. You also have to pay for costs over your benefit limit.*
Mental Health Services	Inpatient visit: Days 1-5: $350 copay* per admission. Days 6-90: $0 copay. Outpatient group therapy visit: $0 copay Outpatient individual therapy visit: $0 copay *Prior authorization is required for inpatient services.*
Skilled Nursing Facility (SNF)	$0 copay days 1 - 20 $221 copay days 21 - 100* Our plan covers up to 100 days in a SNF per admission. *Prior authorization is required.*
Physical Therapy	Physical therapy, occupational therapy, and speech and language therapy visit: 20% coinsurance* *Prior authorization is required.*
Ambulance	Ground Ambulance: 20% coinsurance* Air Ambulance: 20% coinsurance* *Prior authorization may be required.*
Transportation	$0 copay. 12 one-way trips to plan-approved locations every year (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. Limit of 50 miles per one-way trip.*
Medicare Part B Drugs	20% coinsurance will be applied to non-preferred chemotherapy and non-preferred other Part B drugs.*

Benefits/Services	AmeriHealth Caritas VIP Care Choice (HMO D-SNP)
Medicare Part B Drugs (continued)	0% coinsurance for preferred Part B chemotherapy and radiation drugs. 20% coinsurance or $35, whichever is less for Part B insulin drugs.* *Prior authorization may be required.*

**IMPORTANT: If you receive assistance from Medicaid or "Extra Help," you may pay less than the cost-sharing amounts and premium listed in this document. If your category of Medicaid eligibility or level of Extra Help changes, your cost share may increase or decrease. Please refer to the Evidence of Coverage for additional benefit details.*

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Yearly Deductible stage</td><td>Prescription Drug Deductible: $120 for tiers 3, 4 and 5. If you receive "Extra Help" from Medicare, your deductible is $0. If your category of Medicaid eligibility or level of Extra Help changes, your cost share may increase or decrease. Please refer to the Evidence of Coverage for additional benefit details.</td></tr>
<tr><td>Initial Coverage stage</td><td>You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move on to the Catastrophic Coverage Stage.*
<table>
<tr><th colspan="4">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$3 copay</td><td>$6 copay</td><td>$9 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>25% coinsurance</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>25% coinsurance</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>31% coinsurance</td><td>N/A</td><td>N/A</td></tr>
<tr><th colspan="4">Standard Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$3 copay</td><td>$6 copay</td><td>$9 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>25% coinsurance</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
</table></td></tr>
</table>

PRESCRIPTION DRUG BENEFITS				
	Tier 4 (Non-Preferred Drug)	25% coinsurance	25% coinsurance	25% coinsurance
	Tier 5 (Specialty Tier)	31% coinsurance	N/A	N/A
	Please call us or see the plan's **"Evidence of Coverage"** on our website www.amerihealthcaritasvipcare.com/de/choice for complete information about your costs for covered drugs.			
Catastrophic Coverage stage	$0 copay			

Additional Benefits/Services	AmeriHealth Caritas VIP Care Choice (HMO D-SNP)
Fitness Benefit	$0 copay per visit SilverSneakers® is a free fitness benefit which includes access to participating SilverSneakers® fitness facilities, online wellness resources, and classes.
Home Health Care	$0 copay Covered services include, but are not limited to: • Home Health Services *Prior authorization is required.*
Meal Benefit, post-discharge	$0 copay The post-discharge meal benefit covers 14 meals over the course of one week for qualified homebound members within 30 days of each discharge from an inpatient facility or a skilled nursing facility, up to four times per year. *A referral is required.*
Medical Equipment /Supplies	0 - 20% coinsurance for the following equipment/supplies* 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. Prosthetics/Medical Supply: Prior authorization is required for rental and purchased Medicare-covered prosthetics and medical supplies. Diabetic Supplies Non-preferred brands and all continuous glucose monitors will require prior authorization and have a 20% coinsurance. Preferred brands have a $0 copay.

Opioid Treatment Program Services	20% coinsurance* • Substance use counseling. • Individual and group therapy.
Outpatient Rehabilitation	20% coinsurance* • Cardiac (heart) rehabilitation services • Pulmonary Rehab • SET *Prior authorization is required.*
Over-the-counter Items (OTC) and Daily Living Supports	Members are provided a combined allowance of $58 each month to spend on the following benefits: **Over-the-counter (OTC)** All members may use the combined allowance towards eligible OTC items. 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 month or upon disenrollment from the plan. Naloxone is covered as a Part C OTC benefit. The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. **Home and Bathroom Safety Devices** All members may use the combined allowance towards eligible home and bathroom safety devices such as grab bars or doorknobs, 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 month or upon disenrollment from the plan. **Special Supplemental Benefits for the Chronically Ill (SSBCI)** If you qualify for SSBCI, you may also use the combined allowance towards everyday living expenses. The allowance can be used for: • Healthy foods • General supports for living (e.g., rent, mortgage, utilities) Not all members qualify. Only SSBCI eligible members may use their allowance

Over-the-counter Items (OTC) and Daily Living Supports (continued)	towards rent, utilities, internet, and healthy foods. In order to qualify for SSBCI, members must have at least one of the following chronic health conditions: Cardiovascular disorders, Chronic and disabling mental health conditions, Chronic gastrointestinal disease (limited to end-stage liver disease), Congestive heart failure, Chronic lung disorders (limited to chronic obstructive pulmonary disease), Connective Tissue Disease, Dementia, Diabetes mellitus, Stroke, and/or Overweight, obesity, and metabolic syndrome. In addition: The condition must be life threatening or greatly limit overall health or function of the member; the member must be at high risk of hospitalization or other adverse health outcomes; and the member must require intensive care coordination. The plan will review objective criteria to determine a member's eligibility. For more information or to check eligibility, members should contact the plan. Limitations apply. **In addition, you must satisfy at least one of the following:** • Had one or more inpatient admissions (inclusive of behavioral health) related to the chronic condition in the last 12 months. • Had one or more urgent care or emergency room visits related to the chronic condition in the last 12 months. • Had two or more outpatient visits related to the chronic condition (including primary care or specialty care visits) in the last 12 months. • Are a patient who requires home health visits related to the chronic condition. • Are a patient with one or more chronic conditions and a need for one or more pieces of durable medical equipment (DME) in the outpatient setting, limited to: group 3 power/manual wheelchair, noninvasive ventilation (NIV), BiPAP machines, mechanical in-exsufflation devices, or group 2 or group 3 mattresses.
Podiatry Services	$0 copay per visit 4 routine foot care visits every year.
Telemedicine	$0 copay per visit Telemedicine services are available 24 hours a day, 7 days a week via telephone, desktop, or mobile device. Members can immediately have a medical, counseling, or psychiatry consultation with a physician. Members can also schedule a telemedicine appointment for a later time.

24/7 Nurse Call Line	$0 copay The 24/7 Nurse Call Line is a service available to all members 24 hours a day, seven days a week. The service is designed to provide members with a resource to answer health-related questions and to recommend the appropriate level of care.

**IMPORTANT: If you receive assistance from Medicaid or "Extra Help," you may pay less than the cost-sharing amounts and premium listed in this document. If your category of Medicaid eligibility or level of Extra Help changes, your cost share may increase or decrease. Please refer to the Evidence of Coverage for additional benefit details.*

Medicaid

This information is for people who have both Medicare and Delaware Medicaid.

Some benefits may be covered by both our plan and Delaware Medicaid. If this happens, you must use all of our plan's coverage for that benefit first. Delaware Medicaid may cover the benefit after our plan's coverage is used.

The benefits you can get may depend on your Delaware Medicaid eligibility level.

If you have questions about your eligibility or benefits, check your Medicaid Member Handbook. The handbook has the most current Delaware Medicaid information.

Or call the Division of Medicaid & Medical Assistance (DMMA) at **1-302-255-9500** or **1-800-372-2022**. TTY users can call **711**. Help is available Monday through Friday, from 8 a.m. to 4:30 p.m.

Benefits
Hospital: inpatient and/or outpatient care
Routine doctor office visits, checkups, and sick visits
Well-baby visits, well-child visits, and immunizations
Tests and studies, laboratory work, and X-rays
Skilled nursing facility services
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including periodic preventive health screenings and other necessary diagnostic and treatment services for members ages 20 and younger
Family planning services
Pharmacy
Visits to specialists
Vision services: routine eye exams/ eyeglasses or contact lenses
Nonemergency medical transportation.

Benefits
Private-duty nursing and home health care services
Hospice services
Prenatal and postpartum care, including delivery, birthing center admission, newborn care, and early discharge home visits for new mothers
Durable medical equipment and supplies
Federally qualified health center services
Ambulatory Surgical Center services
Surgery: inpatient and/or outpatient
Prescribed pediatric extended care (PPEC) services for children who are medically and/or technologically dependent.
Preventive services, including mammogram, colonoscopy, and well visits for adults
Telemedicine Services
Tobacco cessation
Chiropractic services
Behavioral health impatient and outpatient services
Licensed behavioral health practitioner services
Radiology services, including invasive and noninvasive imaging
OB/GYN exams and annual Pap tests
Pediatric respite services for members age 20 and younger with a physical or behavioral health condition affecting their ability to care for themselves.
Case management and care coordination services
Dental services for adults (age 21 and older): Now offered with no copay required
Outpatient addiction services and residential addiction services

Benefits
Substance Use Disorder (SUD) treatment services
Medication Assisted Treatment (MAT)
Applied Behavioral Analysis
Organ transplants
Ambulance rides
Physical, speech, and occupational therapy

DISCLAIMERS

You can get this document for free in other formats, such as large print, braille, or audio. Call Member Services at 1-833-467-3302 (TTY: 711), October 1 – March 31, 8 a.m. – 8 p.m., seven days a week. From April 1 – September 30, call 8 a.m. – 8 p.m., Monday through Friday. The call is free.

AmeriHealth Caritas VIP Care Choice is an HMO D-SNP plan with a Medicare Contract and a contract with the Delaware Medicaid Program. Enrollment in AmeriHealth Caritas VIP Care Choice depends on contract renewal.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-467-3302 (TTY 711) del 1.º de octubre al 31 de marzo: de 8 a. m. a 8 p. m., los siete días de la semana, y del 1.º de abril al 30 de septiembre: de 8 a. m. a 8 p. m., de lunes a viernes. La llamada es gratuita.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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

Health coverage is offered by AmeriHealth Caritas VIP Next, Inc.

THANK YOU

Connect with us

Contact Information: 1-833-467-3302, TTY: 711, October 1 – March 31: 8 a.m. - 8 p.m., seven days a week and April 1 – September 30: 8 a.m. - 8 p.m., Monday through Friday.

Organization Name: AmeriHealth Caritas VIP Next, Inc.

Organization website: www.amerihealthcaritasvipcare.com/de/choice

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