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 (HMO D-SNP)

January 1, 2027 – December 31, 2027

H4227_002_128435_M_Accepted_09142026

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/pa.

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 (HMO D-SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **AmeriHealth Caritas VIP Care (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 (HMO D-SNP)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

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

Hours of Operation & Contact Information

- Call 1-866-533-5490 (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 1-855-241-3648, (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/pa.

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

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

- Qualified Medicare Beneficiary Plus **(QMB+)**.
- Specified Low-Income Medicare Beneficiary Plus **(SLMB+)**.
- Full Benefit Dual Eligible **(FBDE)**.

You must live in our service area. **Our service area includes these counties in Pennsylvania: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming and York.**

For prospective enrollees, if you have questions about your eligibility, call **1-855-241-3648, (TTY 711)**.

Which doctors, hospitals, and pharmacies can I use?

- AmeriHealth Caritas VIP Care (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 (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/pa.
- 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/pa.
    - 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 (HMO D-SNP)

2 SECTION II - SUMMARY OF BENEFITS

AmeriHealth Caritas VIP Care (HMO D-SNP)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**AmeriHealth Caritas VIP Care (HMO D-SNP)**
Monthly Plan Premium	You do not pay a separate monthly plan premium for AmeriHealth Caritas VIP Care (HMO D-SNP). You must continue to pay your Medicare Part B premium.
Deductible	Prescription Drug Deductible: $700. 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: • **$9,850** 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.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**AmeriHealth Caritas VIP Care (HMO D-SNP)**
Inpatient Hospital Coverage	$0 copay per stay *Prior authorization is required.*
Outpatient Hospital Coverage	Outpatient hospital: $0 copay Outpatient Surgery: $0 copay *Not all outpatient preventive or diagnostic services will require prior authorization.*
Ambulatory Surgical Center (ASC) Services	Ambulatory Surgical Center: $0 copay *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: $0 copay
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	$0 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	$0 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 (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: $0 copay Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay Outpatient X-rays: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): $0 copay *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: $0 copay 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 Select hearing aid technology levels through NationsHearing at no cost to the member. All hearing aids offered through NationsHearing include: • 60-day evaluation period with a 100% money-back guarantee (no restocking fees) • 1 Hearing aid fitting per hearing aid • 3 follow-up appointments within one year of the fitting date • 3-year supply of batteries (for non-rechargeable hearing aids, up to 60 cells per ear, per year) • 3-year comprehensive manufacturer's warranty, including one time replacement for lost or damaged hearing aids • Earmold(s) (first set, when needed) • Unlimited ongoing member support via NationsHearing
Dental Services	Preventive dental services: • Oral exam (up to 1 visit(s) every six months): $0 copay. • Cleaning (up to 1 visit(s) every six months): $0 copay.

Benefits/Services	AmeriHealth Caritas VIP Care (HMO D-SNP)
Dental Services (continued)	• Fluoride treatment (up to 1 visit(s) 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. $4,750 plan coverage limit for comprehensive dental benefits every year. 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 fit properly without needing a new denture. *Prior authorization required for comprehensive dental services. Additional service limits may also apply. You are responsible for amounts beyond the benefit limit.*
Vision Services	Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyewear after cataract surgery: $0 copay Contact lenses OR Eyeglasses: Our plan pays up to $475 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	$0 copay • Inpatient visit. • Outpatient group therapy visit. • Outpatient individual therapy visit.

Benefits/Services	AmeriHealth Caritas VIP Care (HMO D-SNP)
Mental Health Services (continued)	*Prior authorization is required for inpatient services.*
Skilled Nursing Facility (SNF)	$0 copay per stay *Prior authorization is required.*
Physical Therapy	Physical therapy, occupational therapy, and speech and language therapy visit: $0 copay *Prior authorization is required.*
Ambulance	Ground Ambulance: $0 copay Air Ambulance: $0 copay *Prior authorization may be required.*
Transportation	$0 copay. 20 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. 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.*

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Yearly Deductible stage</td><td>Prescription Drug Deductible: $700 for tiers 2, 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>23% coinsurance</td><td>23% coinsurance</td><td>23% coinsurance</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>25% 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>
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</table>

Please call us or see the plan's "Evidence of Coverage" on our website www.amerihealthcaritasvipcare.com/pa for complete information about your costs for covered drugs.
</td></tr>
<tr><td>Catastrophic Coverage stage</td><td>$0 copay</td></tr>
</table>

Additional Benefits/Services	AmeriHealth Caritas VIP Care (HMO D-SNP)
Additional Smoking and Tobacco Use Cessation	$0 copay per visit Four additional face-to-face primary care provider visits for smoking/tobacco cessation annually. This is in addition to Medicare's eight covered visits, for a total of 12 visits in a 12-month period.
Chiropractic Care	$0 copay per visit The plan covers manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).
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 copay 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.

Medical Equipment/Supplies (continued)	• 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	$0 copay • Substance use counseling. • Individual and group therapy.
Outpatient Rehabilitation	$0 copay • 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 $250 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

Over-the-counter Items (OTC) and Daily Living Supports (continued)	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) • Non-medical transportation • Pest control Not all members qualify. Only SSBCI eligible members may use their allowance towards rent, utilities, internet, healthy foods, pest control and non-medical transportation. 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.

Medicaid

The following services are not covered by AmeriHealth Caritas VIP Care but are available through Medicaid:

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package	
Services	**Adult Benefit Package**
Category 1 : Ambulatory Services	
Primary Care Provider	No limits
Physician Services	Some specialist services may have limits.
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits
Clinic	Some specialist services may have limits.
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractor Services	No limits
Optometrist Services	• 2 visits (exams) per calendar year • Participants may have additional eye exams (up to 2 additional exams per calendar year) if the eye doctor completes a form.
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 consecutive days in a 60-day certification period.
Radiology (For example: X-Rays, MRIs, and CTs)	No limits
Dental Care Services	• Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation **Key Limitations:**

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Dental Care Services (continued)	• Dentures - 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime • Denture relines - either full or partial, limited to 1 arch every 2 calendar years • Oral exams - 1 per 180 days • Dental prophylaxis - 1 per 180 days • Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years • Crowns, Periodontics and Endodontics only via approved benefit limit exception
Non-Emergency Medical Transport	Non-Emergency Medical Transportation not covered by the Medical Assistance Transportation Program (MATP)
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	No limits
Category 2: Emergency Services	
Emergency Room	No limits
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Category 4: Maternity and Newborn	
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Prescription Drugs	
Prescription Drugs	No limits

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Nutritional Supplements	No limits
Category 6: Rehabilitation and Habilitation Services and Devices	
Skilled Nursing Facility	365 days per calendar year
Home Health Care includes nursing, aide and therapy services	Unlimited for first 28 days; limited to 15 days every month thereafter
ICF/IID and ICF/ORC	Requires an institutional level of care (No limits)
Durable Medical Equipment	No limits
Prosthetics and Orthotics	• Orthopedic Shoes and Hearing Aids are not covered • Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications • Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint • Coverage for low vision aids and eye protheses is limited to 1 per 2 calendar years. • Coverage for an eye ocular is limited to 1 per calendar year
Eyeglass Lenses	Limited to individuals diagnosed with aphakia and cataracts - 4 lenses per calendar year
Eyeglass Frames	Limited to individuals diagnosed with aphakia and cataracts - 2 frames per calendar year. Deluxe frames not included.
Contact Lenses	Limited to individuals diagnosed with aphakia and cataracts - 4 lenses per calendar year

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Medical Supplies	No limits
Therapy (physical, occupational, speech) – Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider
Therapy (physical, occupational, speech) – Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider
Category 7: Laboratory Services	
Laboratory	No limits
Category 8: Preventive/Wellness Services and Chronic Care	
Tobacco Cessation**	70, 15-minute units per calendar year

**Tobacco cessation is one of the preventive services as recommended by the US Preventive Services Task Force. For a full listing of preventive services beyond tobacco cessation, please contact your MCO.

Home and Community-Based Services (HCBS) Services & Limits	
Services	**Limits**
Adult Daily Living Services	
Assistive Technology	
Behavior Therapy	
Benefits Counseling	
Career Assessment	
Chore Services	Chore Services are limited to 40 hours per participant per calendar year and can only be provided when neither the participant, their primary caregiver, nor anyone else in the household is capable of performing the household tasks, neither the person nor anyone else in the household is financially able to provide Chore Services, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision.
Cognitive Rehabilitation Therapy	
Community Integration	Under Community Integration: • Each distinct goal may not be more than twenty-six (26) weeks • No more than 32 units per week for one goal will be approved • If the participant has multiple goals, no more than 48 units per week will be approved However, the Office of Long-Term Living retains the

Home and Community-Based Services (HCBS) Services & Limits	
Services	**Limits**
Community Integration (continued)	discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks.
Community Transition Services	Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as preauthorized by the State Medicaid Agency program office.
Counseling	
Employment Skills Development	Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval.
Financial Management services	No limits
Home Adaptations	
Home Delivered Meals	
Home Health Aide	
Home Health – Nursing	
Home Health – Occupational Therapy	
Home Health – Physical Therapy	
Home Health – Speech and Language Therapy	

Home and Community-Based Services (HCBS) Services & Limits	
Services	**Limits**
Job Coaching	Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval.
Job Finding	
Non-Medical Transportation	
Nutritional Consultation	
Participant-Directed Community Supports	
Participant-Directed Goods and Services	
Personal Assistance Services	
Personal Emergency Response System (PERS)	
Pest Eradication	
Residential Habilitation	
Respite	
Service Coordination	
Specialized Medical Equipment and Supplies	Under Specialized Medical Equipment and Supplies non-covered items include: • All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream)

Home and Community-Based Services (HCBS) Services & Limits	
Services	**Limits**
Specialized Medical Equipment and Supplies (continued)	• Items covered under third party payer liability • Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability • Food, food supplements, food substitutes (including formulas), and thickening agents • Eyeglasses, frames, and lenses • Dentures • Any item labeled as experimental that has been denied by Medicare and/or Medicaid • Recreational or exercise equipment and adaptive devices for such
Structured Day Habilitation	
TeleCare	
Teleservices	No limits
Vehicle Modification	

For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before the HCBS services can be accessed. Additionally, Medicare and other third-party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

DISCLAIMERS

You can get this document for free in other formats, such as large print, braille, or audio. Call Member Services at 1-866-533-5490 (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 is an HMO D-SNP plan with a Medicare Contract and a contract with the Pennsylvania Medicaid Program. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal.

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 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 Vista Health Plan, Inc.

THANK YOU

Connect with us

Contact Information: 1-866-533-5490, 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: Vista Health Plan, Inc.

Organization website: www.amerihealthcaritasvipcare.com/pa

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