
OMB Approval 0938-1444 (Expires: June 30, 2026)

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711),
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. The call is free. For more information, visit
www.firstchoicevipcare.com.



First Choice VIP Care (HMO D-SNP) offered by Select Health of South Carolina

Annual Notice of Change for 2026

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, rules, and costs. This *Annual Notice of Change* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at www.firstchoicevipcare.com. Call Member Services at the number at the bottom of the page to get a copy by mail. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Additional resources

- This document is available for free in Spanish.
- You can get this Annual Notice of Change for free in other formats, such as large print, braille, or audio. Call 1-888-996-0499 (TTY 711), 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. The call is free.
- We'll also ask for your preference during our Welcome call and later in the year, when you contact the plan. The plan will store your request and continue to send future documents in the requested format, unless you ask us to cancel or change the request.
- You can cancel or change your request at any time, simply by calling member Services. The calls are free.

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A. Disclaimers

First Choice VIP Care is an HMO D-SNP plan with a Medicare contract and a contract with the South Carolina Healthy Connections Medicaid program. Enrollment in First Choice VIP Care depends on contract renewal.

B. Reviewing your Medicare and South Carolina Healthy Connections Medicaid coverage for next year

It's important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information on changes to your benefits for next year.

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

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

- Medicare options in the table in **Section G2** "Changing plans".
- Healthy Connections Medicaid options in **Section G2** "Changing plans".

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B1. Information about First Choice VIP Care

- **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-996-0499 (TTY 711) de lunes a viernes, de 8 a. m. a 8 p. m., del 1 de abril al 30 de septiembre; o los siete días de la semana, de 8 a. m. a 8 p. m., del 1 de octubre al 31 de marzo. La llamada es gratuita.
- First Choice VIP Care is a health plan that contracts with both Medicare and Healthy Connections Medicaid to provide benefits of both programs to members.
- When this *Annual Notice of Change* says “we,” “us,” “our,” or “our plan,” it means First Choice VIP Care.

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
 - Are there any changes that affect the services you use?
 - Review benefit and cost changes to make sure they'll work for you next year.
 - Refer to **Section E1** for information about benefit and cost changes for our plan.
- **Check if there are any changes to our drug coverage that may affect you.**
 - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy or quantity limits?
 - Review changes to make sure our drug coverage will work for you next year.
 - Refer to **Section E2** for information about changes to our drug coverage.
 - Your drug costs may have risen since last year.
 - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.

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- Keep in mind that your plan benefits determine exactly how much your own drug costs may change.
- **Check if your providers and pharmacies will be in our network next year.**
 - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
 - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
 - How much will you spend out-of-pocket for the services and drugs you use regularly?]
 - How do the total costs compare to other coverage options?
- **Think about whether you're happy with our plan.**

If you decide to stay with First Choice VIP Care:

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in First Choice VIP Care.

If you decide to change plans:

If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our plan name

On January 1, 2026, our plan name changes from First Choice VIP Care Plus Medicare-Medicaid Plan (MMP) to First Choice VIP Care (HMO D-SNP). You will get a new ID card in the

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mail before January 1, 2026. Any plan materials you receive after January 1, 2026 will have the new plan name.

D. Changes to our network providers and pharmacies

Amounts you pay for your drugs depend on which pharmacy you use. Our plan has a network of pharmacies. In most cases, your prescriptions are covered *only* if they're filled at one of our network pharmacies.

Our provider and pharmacy networks have changed for 2026.

Please review the 2026 Provider and Pharmacy Directory to find out if your providers (primary care provider, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at www.firstchoicevipcare.com. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook* or call Member Services at the number at the bottom of the page for help.

E. Changes to benefits and costs for next year

E1. Changes to benefits for medical services

We're changing our coverage for certain medical services next year. The table below describes these changes.

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

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	2025 (this year)	2026 (next year)
	The plan pays for the following services: • Adjustments of the spine to correct alignment • Diagnostic x-rays	Covered services include: • Manual manipulation of the spine to correct subluxation • Routine services covered: ○ Up to a combined total of 20 medically necessary Acupuncture and Routine Chiropractic Care (Non-Medicare) visits per year.
Dental Services	You pay a \$0 copay. The plan pays for the following services: • Emergency medical procedures performed by oral surgeons. • Dental procedures related to the following: • Organ transplants • Oncology • Radiation of the head and/or neck for cancer treatment • Chemotherapy for cancer treatment • Total joint replacement • Heart valve replacement • Trauma treatment performed in a hospital or ambulatory surgical center	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 – 1 every 5 years (frequency varies by service) ○ 1 full mouth radiograph and 1 panoramic radiograph every 5 years

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	2025 (this year)	2026 (next year)
	We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include: • Reconstruction of the jaw following fracture or injury • Tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. Prior authorization is required.	○ Up to 6 bitewing or periapical radiographs every year. Comprehensive: The combined total of comprehensive dental benefits cannot exceed \$3,000 every year. The comprehensive dental benefits include the following services, up to a \$3,000 combined limit every year: • Restorative Services ○ Minor restorations (fillings). • Endodontics: ○ Service limitations apply. ○ 1 per tooth per lifetime. ○ Pre and post-op radiographs required. ○ Prior authorization required. • Periodontics: ○ Service limitations apply. ○ Prior authorization required. ○ Scaling and Root Planning - 1 per 24 mo. Per quadrant. ○ Debridement once per year.

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	2025 (this year)	2026 (next year)
		○ Scaling in the presence of gingival inflammation once per year. • Prosthodontics, removable ○ Dentures, 1 per arch every 5 years. ○ Denture repair and reline, 1 per year. ○ Prior authorization required. • Maxillofacial prosthetics ○ 1 per arch every 5 years. ○ Prior authorization required. • Implant services benefits ○ Mini-implants (lower arch only) and implant supported denture (lower arch only), 1 every 5 years. ○ Fixed bridges and all other dental implants except for mini-implants are not covered. ○ Prior authorization required. • Prosthodontics, fixed ○ Crowns, 1 every 5 years, per tooth. No more than 4 per calendar year, with no more than 2 crowns per arch per year.

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	2025 (this year)	2026 (next year)
		○ Prior authorization required. ● Oral and maxillofacial surgery ○ Extractions - 1 per tooth per lifetime. Other oral surgery, limitations apply. ○ Prior authorization required.
Diabetes Management Services	You pay a \$0 copay. Diabetes Management Services are available, in an outpatient setting, to you if your primary care provider thinks will benefit from a diabetes management service. If you have a Type 1, Type 2, and/or gestational diabetes may be eligible for Diabetes Management Services. You are not eligible for Diabetes Management Services while residing in an inpatient hospital or other institutional setting such as a nursing care facility or a residential care facility. Diabetes Management Services providers may only	Diabetes Management Services aren't covered.

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	2025 (this year)	2026 (next year)
	bill for the Initial Assessment once per provider per lifetime. You are allowed 10 hours of diabetes education per lifetime. The 10 hours of instruction may be conducted as either individual OR group instruction.	
Diabetic Supplies	You pay a \$0 copay. The plan pays for the following services for all people who have diabetes (whether they use insulin or not): - Supplies to monitor your blood glucose, including the following: - Blood glucose monitor - Blood glucose test strips - Lancet devices and lancets - Glucose-control solutions for checking the accuracy of test strips and monitors - For people with diabetes who have severe diabetic foot disease, the plan pays for the following: - One pair of therapeutic custom-molded shoes (including inserts) and	You pay a \$0 copay. For all people who have diabetes (insulin and non-insulin users). Covered services include: - Supplies to monitor your blood glucose: - Blood glucose monitor - Blood glucose test strips - Lancet devices and lancets - Glucose-control solutions for checking the accuracy of test strips and monitors - For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: - One pair per calendar year of therapeutic custom-molded shoes including: - Inserts provided with such shoes)

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	2025 (this year)	2026 (next year)
	two extra pairs of inserts each calendar year - One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes - Training to help you manage your diabetes, in some cases - You are eligible for Diabetes Management Services if your provider determines this will help you. - You are limited to 10 hours of diabetes education in your lifetime. - The plan pays for Continuous Glucose Monitors (CGMs) and their accompanying supplies Prior Authorization is required for non-preferred brands of diabetic supplies and all Continuous Glucose Monitors	- Two additional pairs of inserts, or one pair of depth shoes - Three pairs of inserts (not including the non-customized removable inserts provided with such shoes) - Fitting - Diabetes self-management training is covered under certain conditions. - Continuous Glucose Monitors (CGMs) and their accompanying supplies Non-preferred brand of diabetic supplies and all continuous glucose monitors will require a prior authorization and will have a 20% co-insurance. Once the beneficiary reaches the maximum out of pocket limit, the copay will be \$0.

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	2025 (this year)	2026 (next year)
	and their accompanying supplies.	
Durable Medical Equipment (DME)	You pay a \$0 copay. The following items are covered: • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers Other items may be covered. We will pay for all medically necessary DME that Medicare and Healthy Connections Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	You pay a \$0 copay. Covered items include, but are not limited to: • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • IV infusion • Pumps • Speech generating devices • Oxygen equipment, • Nebulizers • Walkers We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. Prior Authorization is required for:

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	2025 (this year)	2026 (next year)
	White canes for the blind are not covered. The plan rents most DME items for you for a maximum of 10 months. In some cases, it may be 13 months. At the end of the rental period, our plan transfers ownership of the DME item to you, and it is considered purchased. Our plan may pay for maintenance fees. Prior Authorization is required for all Medicare and Healthy Connection Medicaid DME items. However, case managers from CLTC may authorize durable medical equipment for waiver participants.	• Medicare-covered DME items over \$750 for purchase. • Rental and rent-to-purchase items. The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item • Enteral Nutritional Supplements
Health and wellness education programs	You pay a \$0 copay. The plan has a range of health and wellness education programs activities for members, their family members, and other informal caregivers. Some examples of topics that maybe covered are: • Self-management for chronic conditions • Quitting smoking • Preventing falls	Health and wellness education programs aren't covered.

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	2025 (this year)	2026 (next year)
	- Caregiver support - Nutrition - Alcohol and drug abuse - Managing your medications - Fitness - Disease planning - Preparing for emergencies We offer three specific health and wellness education programs: - Preventive Services for Primary Care Enhancement (PSPCE) helps prevent disease, disability, and other health conditions. These services may also slow down the disease, help members live longer, and promote physical and mental health. PSPCE encourages members to see their primary care providers to achieve positive health outcomes. - Rehabilitative Services for Primary Care Enhancement (RSPCE) help reduce physical or mental disability and get members functioning the best they can. - Needs Assessment and Intervention Case Plan is	

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	2025 (this year)	2026 (next year)
	a screening to see if a member is a good fit for a program, project, or treatment protocol.	
Hearing Services	You pay a \$0 copay. Routine hearing services - You must see a TruHearing® provider to use this benefit. - Up to one routine hearing exam every year - The plan pays up to \$1,500 toward the cost of non-implantable hearing aids(s) from the applicable TruHearing® Choice catalog every 3 years. Hearing Aid purchase includes: - Up to 3 fittings for a hearing aid every 3 years. During the first 12 months after a TruHearing-brand hearing aid purchase, the plan will cover a limited number of follow-up visits for fitting and adjustments. The benefit does not apply to any other hearing aid brands. 80 batteries per hearing aid for non-rechargeable models	You pay a \$0 copay. We cover: - Up to one routine hearing exam every year - The plan pays up to \$2,500 toward the cost of non-implantable hearing aids(s) from the applicable TruHearing® Choice catalog every 3 years. The allowance covers the cost of two non-implantable TruHearing branded Advanced hearing aids every three years (limit 1 hearing aid per ear). After plan-paid benefit, you are responsible for the remaining costs. You must see a TruHearing provider to use this benefit. Hearing aid purchase includes: - First 12 months of follow-up provider visits 60-day trial period 3-year extended warranty

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	2025 (this year)	2026 (next year)
	60-day trial period. 60-day trial periods allow you to try the hearing aid(s) for the allotted amount of time. If, for any reason, you want to return or exchange the hearing aid(s) during that time, you can do so at no additional charge. If you exchange the hearing aid(s) for a different style, the trial period will start over when they receive the new aid(s).	80 batteries per aid for non-rechargeable models
In-Home Safety Assessment	You pay a \$0 copay. An in-home safety assessment is included in the comprehensive assessment.	In-Home Safety Assessment isn't covered.
Intensive Outpatient Program Services	Intensive Outpatient Program Services were not covered.	You pay a \$0 copay. Prior authorization is required.
Meal Benefit	Meal Benefit isn't covered.	You pay \$0 The post-discharge meal benefit covers 14 meals over the course of one week for qualified homebound members after each

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		discharge from an inpatient facility or a skilled nursing facility Up to four times per year Referral is required.
Medicare Part B Prescription Drugs	You pay a \$0 copay.	You pay a \$0 copay. 0% coinsurance for preferred Part B drugs. 20% or \$35, whichever is less for preferred Part B insulin drugs for 1 month supply
Over-the-Counter (OTC) Items	You pay a \$0 copay. Up to \$100 per quarter may be spent for over-the-counter items included in the OTC catalog and/or online ordering portal. - You may purchase up to six products per category per quarter. - There is no limit on the number of items in your order. - OTC orders are limited to three orders per quarter. - Additional limits may apply to some items. - Any unused balance will automatically expire at the end of each quarter or	You pay \$0. \$106 per quarter to spend on eligible OTC items such as vitamins, pain relievers, cold remedies, rent/utilities, pest control and more. - Funds are loaded to a plan-issued debit card each month - Members can shop through the OTC catalog or at participating retail stores - No limit on the number of items or orders - Unused amounts expire at the end of each quarter or upon disenrollment from the plan

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	upon disenrollment from the plan. Coverage includes Naloxone.	- If a member qualifies, the OTC credit will be combined with the SSBCI credit. - Any unused funds will expire at the end of the quarter or upon disenrollment from the plan.
Part D drug coverage	You pay a \$0 copay.	Drug Tier 1 – Preferred Generic: 25% of the total cost. Drug Tier 2 – Generic: You pay 25% of the total cost. Except for covered insulin products and most adult Part D vaccines You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 3 – Preferred Brand: You pay 25% of the total cost. Except for covered insulin products and most adult Part D vaccines You pay no more than \$35 per month supply of each covered insulin product on this tier.

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		Drug Tier 4 – Non-Preferred Drug: You pay 26% of the total cost. Except for covered insulin products and most adult Part D vaccines. You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 5 – Specialty: You pay 25% of the total cost. Drug Tier 6 – Select Care Drugs: You pay \$0 of the total cost.
Podiatry Services	You pay a \$0 copay. The plan pays for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes	You pay a \$0 copay. The plan will pay for the following services: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs Our plan covers routine podiatry services:

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		9 routine foot care visits every year
Skilled Nursing Facility (SNF)	You pay a \$0 copay. CLTC certification is required prior to any Medicaid-sponsored admission to a long-term care facility from any location, including transition from the community to a nursing facility (noncovered Medicare stay or less than 3-day hospital stay prior to nursing facility admission). - Three (3) levels of care: - Complex Care - Skilled and intermediate Must require 24-hour assistance of skilled medical professional staff. Per diem rate covers room and board services.	You pay a \$0 copay. Prior authorization required.
Special Supplemental Benefits for the Chronically III (SSBCI)	Special Supplemental Benefits for the Chronically III (SSBCI) are not covered.	You pay a \$0 copay. If you qualify for SSBCI you can apply the \$106 monthly OTC credit to help with everyday living expenses. This credit can be used for: Healthy foods

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		• General supports for living (e.g., rent, mortgage, utilities) • Pest control In order to qualify for SSBCI, you must have at least one of the following chronic health conditions: • Cardiovascular disorders • Chronic and disabling mental health conditions • Chronic gastrointestinal disease (limited to end stage liver disease) • Chronic lung disorders (limited to chronic obstructive pulmonary disorder) • Congestive heart failure • Connective tissue disease • Dementia • Diabetes mellitus • Overweight, obesity, & metabolic syndrome • stroke In addition: • The condition must be life threatening • Greatly limit overall health function • You must be at high risk of hospitalization or other adverse health outcomes

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	2025 (this year)	2026 (next year)
		You must require intensive care coordination The plan will review objective criteria to determine your eligibility. For more information or to check eligibility, you should contact the plan. Unused amounts expire at the end of each month or upon disenrollment from the plan.
Transportation Services	You pay a \$0 copay. Transportation Services are not covered by the plan, but you could get non-emergency transportation to and from your medical appointment under your Medicaid benefit.	You pay a \$0 copay. In addition to non-emergency transportation under your Medicaid benefit, our plan covers: 24 one-way trips every year to plan-approved locations (e.g. doctor's office, pharmacy, and hospital). - May consist of a car, shuttle, or van service depending on appropriateness for the situation and the member's needs. - Rides must be scheduled at least one business day in advance except in special circumstances.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



	2025 (this year)	2026 (next year)
		• Transportation is authorized for plan-approved locations only (e.g. doctor's office, pharmacy and hospital). • Limit of 50 miles per one-way trip.
Telemonitoring Services	You pay a \$0 copay. Telemonitoring equipment monitors weight, blood pressure, blood oxygen and glucose levels of consumers. Daily readings are transmitted from the consumer's home to nurses who review the daily results. Doctors are notified if readings are outside of certain ranges.	Telemonitoring Services are not covered.
Vision Care	You pay a \$0 copay. The plan will pay for the following services: • Outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye • Corrective lenses and frames, and replacements if you need them after a cataract removal without a lens implant • Routine Vision	You pay a \$0 copay. Our plan offers routine vision coverage including: • One routine vision exam every year • The plan will cover up to \$355 every year towards eyeglasses or contact lenses. You must receive your care from an in-network provider.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



	2025 (this year)	2026 (next year)
	○ One routine eye exam every year, excluding contact lens exam and fitting services. ○ One pair of eyeglasses (lenses and frames) or one pair of contact lenses is covered every two years. ● There is a \$150 plan coverage limit for eyewear every two years. ● Up to \$150 can be applied towards eyeglasses or contact lenses every two years.	We will only pay for covered vision services if you go to an in-network vision provider. In most cases, you will have to pay for care that you receive from an out-of-network provider.
Worldwide Emergency/Urgent Coverage	Worldwide Emergency/Urgent Coverage isn't covered	You pay a \$0 copay. \$50,000 (USD) combined annual maximum plan benefit amount for Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation

E2. Changes to drug coverage

Changes to our *Drug List*

An updated *List of Covered Drugs* is located on our website at www.firstchoicevipcare.com. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a *List of Covered Drugs*.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



The *List of Covered Drugs* is also called the *Drug List*.

We made changes to our *Drug List*, which could include removing or adding drugs, changing drugs we cover and changes to the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier.

Review the *Drug List* to **make sure your drugs will be covered next year** and to find out if there are any restrictions or if your drug has been moved to a different cost-sharing tier.

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

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

- Work with your doctor (or other prescriber) to find a different drug that we cover.
 - You can call Member Services at the numbers at the bottom of the page to ask for a *List of Covered Drugs* that treat the same condition.
 - This list can help your provider find a covered drug that might work for you.
- Ask us to cover a temporary supply of the drug.
 - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
 - This temporary supply is for up to 30 days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
 - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.

If you received permission from us in 2025 to use a drug that is not on our formulary, known as a formulary exception, in some instances you can continue to use that drug in 2026 as long as your doctor prescribes it for you. Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition. Non-maintenance drugs are those taken for a shorter period of time, for example antibiotics. If you were prescribed a maintenance drug that had specific requirements that you met or were given permission from us to use in 2025, known

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



as a coverage determination, in some instances, you can continue to use this drug in 2026. However, if you received a coverage determination for a non-maintenance drug in 2025, you or your provider will need to again file a coverage determination request to continue using that drug in 2026.

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

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

Some of these drug types may be new to you. For definitions of drug types, please go to **Chapter 12** of your *Member Handbook*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website:

www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients.

You can also call Member Services at the number at the bottom of the page or ask your health care provider, prescriber, or pharmacist for more information.]

Changes to drug costs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay.	During this stage, the plan pays all of the costs of your drugs through December 31, 2026.
You begin this stage when you fill your first prescription of the year.	You begin this stage after you pay a certain amount of out-of-pocket costs.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



The Initial Coverage Stage ends when your total out-of-pocket costs for drugs reaches \$2,100. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you'll pay for drugs.

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

E3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, our plan pays a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

We moved some of the drugs on our *Drug List* to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our *Drug List*.

The following table shows your costs for a one-month supply filled at a network pharmacy with standard copays in each of our <number of tiers> drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

Most adult Part D vaccines are covered at no cost to you.

For information about the costs for a long-term supply; or for mail-order prescriptions go to **Chapter 6, Section D** of your *Member Handbook*.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



	2025 (this year)	2026 (next year)
Drugs in Tier 1 (Preferred Generic) Cost for a one-month supply of a drug in Tier 1 that's filled at a network pharmacy	You pay \$0 copay.	Cost sharing at a retail pharmacy is 25% of the total cost. Your cost for a 61 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without "Extra Help".
Drugs in Tier 2 (Generic) Cost for a one-month supply of a drug in Tier 2 that's filled at a network pharmacy	You pay \$0 copay.	Cost sharing at a retail pharmacy is 25% of the total cost. Your copay for a one-month (30-day) supply is 25% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier. Your cost for a 61 - 100 days mail-order prescription is 25% coinsurance *Cost sharing is based on the level of "Extra Help" the member receives.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



	2025 (this year)	2026 (next year)
Drugs in Tier 3 (Preferred Brand) Cost for a one-month supply of a drug in Tier 3 that's filled at a network pharmacy	You pay \$0 copay.	Cost sharing at a retail pharmacy is 25% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier. Your cost for a 61 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without "Extra Help".
Drugs in Tier 4 (Non-Preferred Drug) Cost for a one-month supply of a drug in Tier 4 that's filled at a network pharmacy	You pay \$0 copay.	Cost sharing at a retail pharmacy is 25% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier. Your cost for a 61 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without "Extra Help".

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



	2025 (this year)	2026 (next year)
Drugs in Tier 5 (Specialty) Cost for a one-month supply of a drug in Tier 5 that's filled at a network pharmacy	You pay \$0 copay.	Cost sharing at a retail pharmacy is 25% of the total cost. Your cost for a 61 - 100 days mail-order prescription is 25% coinsurance. *Cost sharing is based on the level of "Extra Help" the member receives **Deductible and coinsurance may apply for members without "Extra Help".
Drugs in Tier 6 (Select Care Drugs) Cost for a one-month supply of a drug in Tier 6 that's filled at a network pharmacy	You pay a \$0 copay.	You pay \$0 of the total cost.

The Initial Coverage Stage ends when your total out-of-pocket costs reach **\$2,100**. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information about how much you pay for drugs.

E4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit **\$2,100** for your drugs, the Catastrophic Coverage Stage begins and you pay nothing for your covered Part D drugs. You stay in the Catastrophic

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



Coverage Stage until the end of the calendar year. You may have copays for Medicaid covered drugs

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

F. Administrative changes

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



	2025 (this year)	2026 (next year)
Contract Number	H8213	H4739
Organization Type	Demo	Local CCP
Plan Name	First Choice VIP Care Plus	First Choice VIP Care
Plan Type	MMP HMO	HMO
Special Needs Plan Type	Not applicable	Dual-Eligible
Customer Service Phone Number	1-888-978-0862	1-888-996-0499
Pharmacy Customer Service Phone Number	1-855-327-0511	1-833-809-3767
Plan Web Site	http://www.firstchoicevipcareplus.com	www.firstchoicevipcare.com
Medicare Prescription Payment Plan	Not applicable.	The Medicare Prescription Payment Plan may help you manage your drug costs by spreading them out during the year as monthly payments. To learn more about this program, please contact us at the number at the bottom of the page or visit www.Medicare.gov .

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



G. Choosing a plan

G1. Staying in our plan

We hope to keep you as a plan member. You don't have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you'll automatically stay enrolled as a member of our plan for 2026.

G2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you have Healthy Connections Medicaid, you can end your membership in our plan any month of the year.

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

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

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

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

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section G2**. By choosing one of these options, you automatically end your membership in our plan.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



1. You can change to: Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information about Program of All-inclusive Care for the Elderly (PACE), call Healthy Connections Medicaid at 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. You can also go to www.scdhhs.gov/providers/managed-care/program-all-inclusive-care-elderly-pace/members If you need help or more information: • After you contact Medicare about changing plans, Medicare will work with Healthy Connections Medicaid to make the change. For more information about this process, you can call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. • Call the SHIP program, I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711 OR Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins.
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If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



2. You can change to: Original Medicare with a separate Medicare drug plan	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. For more information, please visit www.aging.sc.gov. OR Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.
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If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



3. You can change to: Original Medicare without a separate Medicare drug plan NOTE: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call Insurance Counseling Assistance and Referrals for Elders (I-CARE) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. For more information, please visit www.aging.sc.gov.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. For more information, please visit www.aging.sc.gov. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.
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If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



4. You can change to: Any Medicare health plan during certain times of the year including the Open Enrollment Period and the Medicare Advantage Open Enrollment Period or other situations described in Section A.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information about Program of All-inclusive Care for the Elderly (PACE), call Healthy Connections Medicaid at 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. You can also go to www.scdhhs.gov/providers/managed-care/program-all-inclusive-care-elderly-pace/members If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. For more information, please visit www.aging.sc.gov. OR Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins.
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Your Healthy Connections Medicaid services

For questions about how to get your Healthy Connections Medicaid services after you leave our plan, contact South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. You can also visit

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



www.scchoices.com. Ask how joining another plan or returning to Original Medicare affects how you get your Healthy Connections Medicaid coverage.

H. Getting help

H1. Our plan

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Member Handbook*

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits and costs for 2026. It explains your rights and the rules to follow to get services and drugs we cover.

The *Member Handbook for 2026 will be available by October 15.* You can also review the *Member Handbook* to find out if other benefit or cost changes affect you. An up-to-date copy of the *Member Handbook* is available on our website at www.firstchoicevipcare.com. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2026.

Our website

You can visit our website at www.firstchoicevipcare.com. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List (List of Covered Drugs)*.

H2. The state enrollment broker, South Carolina Healthy Connections Choices

The enrollment broker helps people choose between different Healthy Connections Medicaid health plans, enroll, change plans, or disenroll. The enrollment broker is called South Carolina Healthy Connections Choices, and it isn't connected with any insurance company or health plan. You can call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. For more information, please visit www.scchoices.com.

H3. Getting help from the State Health Insurance Assistance Program (SHIP)

You can also call the State Health Insurance Assistance Program (SHIP). In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. I-CARE counselors can help you understand your plan choices and answer questions about

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



switching plans. I-CARE isn't connected with any insurance company or health plan. The I-CARE phone number is 1-800-868-9095. TTY users should call 711.

H4. Medicare

To get information directly from Medicare:

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

Medicare's Website

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

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

Medicare & You 2026

You can read the *Medicare & You 2026* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

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

H5. Healthy Connections Medicaid

The phone number for Healthy Connections Medicaid is 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. Healthy Connections Medicaid can help or direct you to someone who can help you.

H6. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that may help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December) as monthly payments. This program doesn't save you money or lower your drug costs.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.



“Extra Help” from Medicare and help from your state’s pharmaceutical assistance program (SPAP) and the AIDS Drug Assistance Program (ADAP), for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone. All members are eligible to participate in this program, regardless of income level. To learn more about this program please contact us at the phone number at the bottom of this page or visit www.Medicare.gov.

If you have questions, please call First Choice VIP Care at 1-888-996-0499 (TTY 711), 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. The call is free. **For more information**, visit www.firstchoicevipcare.com.

