Aetna Better Health, Inc. (HMO SNP) offered by COVENTRY HEALTH CARE OF VIRGINIA

Annual Notice of Changes for 2019

You are currently enrolled as a member of Aetna Better Health, Inc. (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 1.6 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. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider & Pharmacy Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you want to **keep** your plan, you don't need to do anything. You will stay in our plan.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between now and December 31. Look in Section 3.2, pages 12-13 to learn more about your choices.

4. **ENROLL: To change plans, join a plan between now and December 31,** 2018

- If you don't join another plan by December 31, 2018, you will stay in Aetna Better Health, Inc. (HMO SNP).
- If you join another plan by December 31, 2018, your new coverage will start the first day of the following month.
- Starting in 2019, there are new limits on how often you can change plans. Look in Chapter 10, Section 2.1 in the *Evidence of Coverage* to learn more.

Additional Resources

- Please contact our Customer Service number at 1-855-463-0933 for additional information. (TTY users should call 711). Hours are 8 am to 8 pm, 7 days a week.
- This document may be made available in other formats such as Braille, large print or other alternate formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aetna Better Health, Inc. (HMO SNP)

- Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. The plan also has a written agreement with the Virginia Medicaid program to coordinate your Medicaid benefits. Enrollment in our plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means COVENTRY HEALTH CARE OF VIRGINIA. When it says "plan" or "our plan," it means Aetna Better Health, Inc. (HMO SNP).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for our plan in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Summary of Benefits* to see if other benefit or cost changes affect you.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	$0	$0
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$0 copay per stay	$0 copay per stay
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: For generic drugs (including brand drugs treated as generic), either $0 copay; or $1.25 copay; or $3.35 copay For all other drugs, either $0 copay, or $3.70 copay, or $8.35 copay	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: For generic drugs (including brand drugs treated as generic), either $0 copay; or $1.25 copay; or $3.40 copay •For all other drugs, either $0 copay, or $3.80 copay, or $8.50 copay

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$6,700	$6,700

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SECTION 1 Changes to Medicare Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.aetnabetterhealth.com/virginia-hmosnp/find-provider. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2019 *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.aetnabetterhealth.com/virginia-hmosnp/find-provider. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2019 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* only tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your 2019 *Evidence of Coverage.* A copy of the *Evidence of Coverage* will be separately mailed to you.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.

Cost	2018 (this year)	2019 (next year)
Blood services (Non-Medicare covered)	Coverage begins with the fourth pint of blood that you need.	Coverage begins with the first pint of blood that you need.
Dental Services (Preventive: Non-Medicare covered)	You pay • a $0 copay for oral exams (two visits every year) • a $0 copay for dental cleanings (two visits every year) • a $0 copay for fluoride treatments (one visit every year) • a $0 copay for dental x-rays (one visit every year) Up to $500 maximum benefit for preventive and non-Medicare covered comprehensive dental services every year	You pay • a $0 copay for oral exams (two visits every year) • a $0 copay for dental cleanings (two visits every year) • a $0 copay for fluoride treatments (one visit every year) • a $0 copay for dental x-rays (one visit every year) Up to $1,500 maximum benefit for preventive and non-Medicare covered comprehensive dental services every year
Dental Services (comprehensive Non-Medicare covered)	You pay • a $0 copay for covered diagnostic services. • a $0 copay for covered endodontic services. • a $0 copay for covered extractions. • a $0 copay for covered periodontics services. • a $0 copay for covered prosthodontics and oral/maxillofacial services. • a $0 copay for covered restorative services. $500 maximum benefit for preventive and non-Medicare covered comprehensive dental services every year.	You pay • Diagnostic services are not covered. • a $0 copay for covered endodontic services. • a $0 copay for covered extractions. • a $0 copay for covered periodontic services. • a $0 copay for covered prosthodontics and oral/maxillofacial services. • a $0 copay for covered restorative services. $1,500 maximum benefit for preventive and non-Medicare covered comprehensive dental services every year.

Cost	2018 (this year)	2019 (next year)
Emergency care (worldwide) Non-Medicare covered	Emergency care received worldwide (i.e. outside the United States) is not covered.	You pay a $0 copay for emergency care received worldwide (i.e. outside the United States).
Health and wellness services		
Health education	Written health education materials are not covered.	You pay 0% of the total cost for written health education materials.
Smoking cessation – additional visits (Non-Medicare covered)	You pay 0% of the total cost for each Non-Medicare covered smoking cessation visit (50 visits every year).	You pay 0% of the total cost for each Non-Medicare covered smoking cessation visit.
Hearing exams (Routine: Non-Medicare covered)	You pay 0% of the total cost for routine hearing exams. (one exam every 2 years)	You pay a $0 copay for routine hearing exams. (one exam every year)
Hearing aids (Non-Medicare covered)	You pay a $0 copay ($1,000 maximum benefit both ears combined every 3 years).	You pay a $0 copay ($2,500 maximum benefit both ears combined every year).
Hearing aid fitting and evaluation (Non-Medicare covered)	You pay a $0 copay (one hearing aid fitting/evaluation every 2 years)	You pay a $0 copay (one hearing aid fitting/evaluation every year)
Over-the-Counter (OTC) Items (Non-Medicare covered)	You pay a $0 copay for over-the-counter items (maximum benefit of up to $50 every month).	You pay a $0 copay for over-the-counter items (maximum benefit of up to $60 every month).
Urgent care (worldwide) Non-Medicare covered	Worldwide urgent care is not covered.	You pay a $0 copay for each worldwide (i.e. outside the United States) urgent care visit.
Vision services: eye exams (Routine: Non-Medicare covered)	Routine eye exams are not covered.	You pay 0% of the total cost (one exam every year).

Cost	2018 (this year)	2019 (next year)
Vision services: eyewear (Non-Medicare covered)	$200 maximum benefit every year. You pay $0 copay for contact lenses Eyeglasses are not covered. Upgrades are not covered.	$250 maximum benefit every year. You pay $0 copay for contact lenses $0 copay for eyeglasses (lenses and frames) $0 copay for upgrades

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days of medication rather than the amount provided in 2018 (up to 98 days of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the

same medical condition. This list can help your doctor to find a covered drug that might work for you.

- You and your doctor can ask the plan to make an exception for you and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage.* Look for Chapter 9, Section 6 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Transition applies to all Part D prescription medications not included on the formulary, or that are on our formulary but with a restriction, such as prior authorization or step therapy. A transition supply will be provided to you at the point-of-sale with exceptions where certain drugs require coverage determination whether it should be covered under Medicare Part B or Part D benefit. In such case, it might require your doctor or pharmacy to provide additional information; therefore the issue may not be resolved at point-of-sale.

- If you are a currently enrolled member who does not request an exception before January 1, 2019, and your current Part D eligible drug therapy coverage is negatively impacted by a formulary change, we will cover up to a 30-day temporary supply of the drug for the first 90 days of the new plan year starting on January 1st.
- If you experience a change in your setting of care (such as being discharged or admitted to a long term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with temporary coverage (at least a 30-day supply) for the applicable drug(s).

Regardless of why you received a temporary supply, you will need to utilize our exception process, as defined in the *Evidence of Coverage*, if you need to continue on the current drug.

Important Note: Please take actions on working with your doctor to find appropriate alternatives covered in the next plan year before January 1st. It will make for a very easy transition into the next calendar year for you. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that you will receive in the mail no later than October 15, 2018. Look for Chapter 9 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30 day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30th, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2018 to 2019.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage.*

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a	Your cost for a one-month supply filled at a network pharmacy: Copayment/Coinsurance during the Initial Coverage Stage: For generic drugs (including brand drugs	Your cost for a one-month supply filled at a network pharmacy: Copayment/Coinsurance during the Initial Coverage Stage: For generic drugs (including brand drugs

Stage	2018 (this year)	2019 (next year)
network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	treated as generic), either $0 copay; or $1.25 copay; or $3.35 copay For all other drugs, either $0 copay, or $3.70 copay, or $8.35 copay Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	treated as generic), either $0 copay; or $1.25 copay; or $3.40 copay For all other drugs, either $0 copay, or $3.80 copay, or $8.50 copay Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**. For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Stage	2018 (this year)	2019 (next year)
Prior Authorization and/or Referral	Prior Authorization and/or Referral requirements are listed in your 2018 *Evidence of Coverage*, Chapter 4 Medical Benefits chart. Your provider is responsible for any prior authorization and/or referral submissions.	Prior Authorization and/or Referral requirements may have changed for 2019. Your provider is responsible for any prior authorization and/or referral submissions. See the Medical Benefits chart in Chapter 4 of your 2019 *Evidence of Coverage* for benefits that require prior authorization.
Membership ID Card	Your ID card contains important information about your plan.	If any of the important information on your ID card changes we will send you a new card. If none of the information on your ID card needs to change, please keep using the same ID card you have now.
Medicare Part B Prescription Drugs	Part B drugs do not have a step therapy requirement.	Part B drugs may be subject to step therapy requirements.

Stage	2018 (this year)	2019 (next year)
Diabetic Supplies	There is no restriction on the brand of glucose meters and/or test strips covered by the plan.	We exclusively cover blood glucose monitors and diabetic test strips manufactured by OneTouch / LifeScan, such as OneTouch Verio® OneTouch Ultra®, OneTouch UltraMini® systems, test strips and supplies. Prior authorization is required for blood glucose monitors in excess of one monitor per year and test strips in excess of 100 per 30 days.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Our Plan

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, our plan offers other Medicare health plans *AND* Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 31. The change will take effect on January 1, 2019

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

Note: Effective January 1, 2019, if you’re in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Virginia, the SHIP is called Virginia Insurance Counseling and Assistance Program (VICAP).

Virginia Insurance Counseling and Assistance Program (VICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare.

Virginia Insurance Counseling and Assistance Program (VICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. You can learn more about Virginia Insurance Counseling and Assistance Program (VICAP) by visiting their website (www.vda.virginia.gov).

For questions about your Department of Medical Assistance Services benefits, contact Department of Medical Assistance Services, 1-800-643-2273, TTY 1-800-343-0634, **Monday through Friday, 8:30 AM to 6:00 PM**. Ask how joining another plan or returning to Original Medicare affects how you get your Department of Medical Assistance Services coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** If you have Medicaid, you are already enrolled in "Extra Help" also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles, and coinsurance. If you qualify, you do not have a coverage gap or late enrollment penalty.If you have questions about Extra Help, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications);
- **Help from your state's pharmaceutical assistance program.** Virginia has a program called Virginia Division for the Aging that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Virginia Department of Health - HIV Care Services, Division of Disease Prevention: ADAP Coordinator. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Virginia Department of Health - HIV Care Services, Division of Disease Prevention: ADAP Coordinator at 1-855-362-0658 TTY (711).

SECTION 7 Questions?

Section 7.1 – Getting Help from Aetna Better Health, Inc. (HMO SNP)

Questions? We're here to help. Please call Customer Service at 1-855-463-0933. (TTY only, call 711). We are available for phone calls 8 am to 8 pm, 7 days a week. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for our plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* will be separately mailed to you.

Visit our Website

You can also visit our website at https://www.aetnabetterhealth.com/virginia-hmosnp. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on “Find health & drug plans”).

Read *Medicare & You 2019*

You can read *Medicare & You 2019* 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. If you don’t have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid, you can call the Department of Medical Assistance Services at 1 (800) 643-2273. TTY users should call 1 (800)-343-0634.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, contact the phone number on your member identification card. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance in writing with the Aetna Medicare Grievance Department, P.O. Box 14067, Lexington, KY 40512. You can also file a grievance by phone by calling the phone number on your member identification card (TTY: 711). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD). You can also contact the Aetna Civil Rights Coordinator by phone at 1-855-348-1369, by email at MedicareCRCoordinator@aetna.com, or by writing to Aetna Medicare Grievance Department, ATTN: Civil Rights Coordinator, P.O. Box 14067 Lexington, KY 40512.

TTY: 711

ENGLISH:
ATTENTION: If you speak a language other than English, free language assistance services are available. Visit our website at www.aetnamedicare.com or call the phone number on your member identification card. (English)

ESPAÑOL (SPANISH):
ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en www.aetnamedicare.com o llame al número de teléfono que se indica en su tarjeta de identificación de afiliado.

简体中文(CHINESE):
请注意：如果您说中文，您可以获得免费的语言援助服务。访问我们的网站www.aetnamedicare.com 或致电您会员卡上的电话号码。

TAGALOG (TAGALOG - FILIPINO):
PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuhang libreng tulong na serbisyo para sa wika. Puntahan ang aming website sa www.aetnamedicare.com o tawagan ang numero ng telepono sa inyong ID kard ng miyembro.

FRANÇAIS (FRENCH):
ATTENTION : Si vous parlez le français, des services gratuits d'aide linguistique sont disponibles. Visitez notre site Web à l'adresse www.aetnamedicare.com ou appelez le numéro de téléphone figurant sur votre carte d'adhérent.

TIẾNG VIỆT (VIETNAMESE):
LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí. Xin truy cập trang web của chúng tôi tại www.aetnamedicare.com hoặc gọi số điện thoại ghi trên thẻ chứng minh thành viên của quý vị.

DEUTSCH (GERMAN):
ACHTUNG: Wenn Sie deutsch sprechen, steht ein kostenloser Dolmetscherservice zur Verfügung. Besuchen Sie unsere Website unter www.aetnamedicare.com oder rufen Sie unter der auf Ihrem Mitgliedsausweis aufgeführten Telefonnummer an.

한국어 (KOREAN):
주의: 한국어를 하시는 분들을 위해 무료 통역 서비스가 제공됩니다. www.aetnamedicare.com에서 웹사이트를 방문하거나 귀하의 회원 ID 카드에 제공된 전화번호로 문의해 주시기 바랍니다.

РУССКИЙ (RUSSIAN):
ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться нашими бесплатными услугами переводчиков. Посетите наш веб-сайт по адресу www.aetnamedicare.com или позвоните по телефону, указанному на вашей карточке-удостоверении.

العربية (ARABIC):
تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية سوف تتوفر لك مجانًا. تفضل بزيارة الموقع الإلكتروني الخاص بنا www.aetnamedicare.comأو اتصل برقم الهاتف الموجود على بطاقة هوية العضو الخاصة بك.

हिंदी (HINDI):
ध्यान दें: अगर आप बात करने में सक्षम हैं हिंदी, तो निशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। हमारी वेबसाइट www.aetnamedicare.com पर विजिट करें या अपने सदस्य पहचान कार्ड पर दिए गए फोन नंबर पर कॉल करें।

ITALIANO (ITALIAN):
ATTENZIONE: Se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Visita il nostro sito web www.aetnamedicare.com o chiama il numero telefonico riportato sulla tua tessera personale.

PORTUGUÊS (PORTUGUESE):
ATENÇÃO: Se você fala português, serviços gratuitos de ajuda para esse idioma estão disponíveis. Visite nosso site www.aetnamedicare.com ou ligue para o número listado em seu cartão de identificação de associado.

KREYOL AYISYEN (FRENCH CREOLE):
ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd gratis nan lang ki disponib pou ou. Ale sou sitwèb nou nan www.aetnamedicare.com oswa rele nimewo telefòn ki nan kat idantifikasyon manm ou.

POLSKI (POLISH):
UWAGA! Osoby mówiące po polsku, mogą skorzystać z bezpłatnych usług pomocy językowej. Proszę wejść na naszą stronę internetową www.aetnamedicare.com lub zadzwonić pod numer telefonu podany na karcie identyfikacyjnej członka.

日本語 (JAPANESE):
ご注意：日本語を話す方を対象に、無料の言語支援サービスを用意しております。当社ウェブサイト www.aetnamedicare.comをご覧いただくか、会員カードに記載の電話番号までお電話ください。

SHQIP (ALBANIAN):
KUJDES: Nëqoftëse flisni shqip, shërbimet e ndihmës gjuhësore janë në dispozicion tuaj falas. Vizitoni Faqen tonë të Internetit në adresën: www.aetnamedicare.com ose telefononi në numrin e telefonit që paraqitet në kartën e identifikimit të anëtarësisë tuaj.

አማርኛ (AMHARIC):
ማሳሰቢያ: አማርኛ የሚናሩ ከሆነ፣ የነጻ የቋንቋ እርዳታ አገልግሎቶች ማግኘት ይችላሉ። ድረ ገጻችንን በ www.aetnamedicare.com ይጎብኙ ወይም በአባልነት መታወቂያዎት ላይ ያለውን ስልክ ቁጥር ይደውሉ።

Հայերեն (ARMENIAN):
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե դուք խոսում հայերեն, անվճար լեզվական օգնության ծառայությունները հասանելի են: Այցելեք մեր կայքը www.aetnamedicare.com կամ զանգահարեք հեռախոսահամարը Ձեր անդամ նույնականացման քարտը:

বাংলা (BENGALI):

মনোযোগ: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। আমাদের ওয়েবসাইট www.aetnamedicare.com ভিজিট করুন অথবা আপনার সদস্য পরিচয় পত্রে দেওয়া ফোন নম্বরে কল করুন।

ភាសាខ្មែរ **(MON-KHMER, CAMBODIAN):**

ប្រយ័ត្ន៖ ប្រសិនបើកអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតឈ្នួលគឺអាចមានសំរាប់បំរើអ្នក។ សូមចូលមើលគេហទំព័ររបស់យើងនៅ www.aetnamedicare.com ឬទូរស័ព្ទមកលេខដែលមាននៅលើកាតសម្គាល់សមាជិករបស់អ្នក។

HRVATSKI (CROATIAN):

PAŽNJA: Ako govorite hrvatski, na raspolaganju su Vam besplatne jezičke usluge. Posjetite našu internetsku stranicu na www.aetnamedicare.com ili nazovite telefonski broj koji se nalazi na Vašoj osobnoj iskaznici člana.

THOŊ MUↃNYJÄŊ (DINKA):

MAAT ŊÏËC KU PÏŊ APƐI: Na yïn jam Thoŋ muↄnyjäŋ, kuↄny loiloi ë looi abec ye Dinka atɔthïïn. Neem wɛpthäit da akïn www.aetnamedicare.com tëdä yuöp ye namba tɔu ë kaan eyï ŋïc ke yï raandɛn.

NEDERLANDS (DUTCH):

LET OP: Als u Nederlands spreekt, is er gratis taalhulp beschikbaar. Bezoek onze website op www.aetnamedicare.com of bel met het telefoonnummer op uw lidmaatschapskaart.

ΕΛΛΗΝΙΚΑ (GREEK):

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Επισκεφθείτε τον ιστότοπο www.aetnamedicare.com ή καλέστε το τηλέφωνο που αναγράφεται στην ταυτότητα μέλους σας.

ગુજરાતી (GUJARATI):

ધ્યાન આપશોઃ જો તમે ગુજરાતી બોલતા હો, તો ભાષા સહાયતા સેવાઓ મફતમાં ઉપલબ્ધ છે. અમારી વેબસાઇટ www.aetnamedicare.com જુઓ અથવા તમારા સભ્ય ઓળખ કાર્ડ પર આપેલા ફોન નંબર પર કૉલ કરો.

HMOOB (HMONG):

LUS CEEV: Yog koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Mus hauv peb tus website www.aetnamedicare.com lossis hu rau tus xov tooj nyob ntawm koj daim npav tswv cuab.

ພາສາລາວ (LAO):

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າ <ພາສາລາວ> ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້. ເຂົ້າເບິ່ງເວັບໄຊທ໌ ຂອງພວກເຮົາໄດ້ທີ່ www.aetnamedicare.com ຫຼື ໂທຫາເບີໂທລະສັບຢູ່ໃນບັດສະມາຊິກຂອງທ່ານ.

DINE' (NAVAJO):

Bilagáana bizaad doo bee yáníłti'da dóó saad nááná ła' bee yáníłti'go, ata' hane' t'áá jíík'e bee áká i'doolwołígíí hóló. Béésh nitsékeesí bee na'ídíkid bá haz'ánígi ąą'ádíílíił éí doodago béésh bee hane'í bee nihich'į' hodíílnih díí naaltsoos bikáá'íjį'. (Navajo)

PENNSYLVANIA DEITCH (PENNSYLVANIA DUTCH):

BASS UFF: Wann du Pennsylvania Deitch schwetzcht kannscht du hilf griege in dei eegni schprooch innings as es dich enich eppes koschte zellt. Pshooch unsa website an www.aetnamedicare.com odda ruf die nummer uff dei ID Kaarte.

فارس **(PERSIAN):**

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمک‌های زبانی به صورت رایگان به شما ارائه می‌شود. از وبسایت ما به نشانی www.aetnamedicare.com دیدن فرمایید و یا با شماره تلفن قید شده بر روی کارت شناسایی عضویت خود تماس بگیرید.

ਪੰਜਾਬੀ **(PUNJABI):**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਬੰਧੀ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਸਾਡੀ ਵੈੱਬਸਾਈਟ www.aetnamedicare.com 'ਤੇ ਜਾਓ ਜਾਂ ਆਪਣੇ ਮੈਂਬਰ ਪਛਾਣ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

ROMÂNĂ (ROMANIAN):

ATENŢIE: Dacă vorbești română, serviciile de asistență lingvistice sunt disponibile gratuit. Vizitează site-ul nostru la www.aetnamedicare.com sau sună la numărul de telefon de pe cardul de identificare de membru.

ܐܬܘܪܝܐ **(SYRIAC):**

ܙܗܘܪܐ: ܐܢ ܐܢܬܘܢ ܟܡ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝܬܘܢ ܕܡܦܠܚܝܬܘܢ ܚܠܡܬܝܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ
ܡܓܢܐܝܬ. ܡܨܝܬܘܢ ܕܣܒܝܬܘܢܠܗ ܒܡܘܩܥܐ ܐܠܩܛܪܘܢܝܐ www.aetnamedicare.com
ܝܢ ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܬܠܝܦܘܢ ܕܝܠܗ ܟܬܝܒܐ ܥܠ ܦܬܩܐ ܕܗܕܡܘܬܐ ܕܝܘܟܘܢ.

ภาษาไทย (THAI):

ข้อควรพิจารณา: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี
โปรดเยี่ยมชมเว็บไซต์ของเราที่ www.aetnamedicare.com
หรือติดต่อหมายเลขโทรศัพท์ที่ระบุไว้ในบัตรสมาชิกของคุณ

УКРАЇНСЬКА (UKRAINIAN):

УВАГА: якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги перекладача. Відвідайте наш веб-сайт www.aetnamedicare.com, або зателефонуйте на номер, вказаний у вашому членському посвідченні.

اردو **(URDU):**

توجہ فرمائیں: اگر آپ اردو زبان بولتے ہیں، تو مفت لسانی معاونت کی سروسز دستیاب ہیں۔ www.aetnamedicare.com پر ہماری ویب سائٹ ملاحظہ کریں یا اپنے رکن شناختی کارڈ پر موجود فون نمبر پر کال کریں۔

עברית (**YIDDISH**):

שימו לב: אם אתם מדברים עברית, זמינים שירותי סיוע בשפה שלכם ללא תשלום. בקרו באתר האינטרנט שלנו www.aetnamedicare.com או התקשרו למספר הטלפון שמופיע על כרטיס החברות שלכם.

Aetna Better Health, Inc. (HMO SNP) Customer Service

Method	Customer Service – Contact Information
CALL 	1-855-463-0933 Calls to this number are free. Hours are 8 am to 8 pm, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
TTY 	711 Calls to this number are free. Hours are 8 am to 8 pm, 7 days a week.
FAX	1-855-259-2087
WRITE 	Aetna Better Health of Virginia 7400 W Campus Rd New Albany, OH 43054
WEBSITE 	https://www.aetnabetterhealth.com/virginia-hmosnp

Virginia Insurance Counseling and Assistance Program (VICAP): Virginia SHIP

Virginia Insurance Counseling and Assistance Program (VICAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-552-3402
TTY	711
WRITE	1610 Forest Avenue, Suite 100 Henrico, VA 23229
WEBSITE	www.vda.virginia.gov