Aetna Better Health of Virginia (HMO D-SNP) offered by COVENTRY HEALTH CARE OF VIRGINIA, INC.

Annual Notice of Changes for 2021

You are currently enrolled as a member of Aetna Better Health of Virginia (HMO D-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 2021 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 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, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?

- Look in Section 1.3 for information about our Provider 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 www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 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 don't join another plan by December 7, 2020, you will be enrolled in Aetna Better Health of Virginia (HMO D-SNP).
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 2.2 to learn more about your choices.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Aetna Better Health of Virginia (HMO D-SNP).
- If you join another plan between **October 15** and **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services 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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aetna Better Health of Virginia (HMO D-SNP)

- Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.
- When this booklet says "we", "us", or "our", it means COVENTRY HEALTH CARE OF VIRGINIA, INC.. When it says "plan" or "our plan", it means Aetna Better Health of Virginia (HMO D-SNP).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for *Aetna Better Health of Virginia (HMO D-SNP)* in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at www.aetnabetterhealth.com/virginia-hmosnp. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (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

Cost	2020 (this year)	2021 (next year)
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 $0.00; or $1.30; or $3.60 per prescription. For all other drugs, either $0.00; or $3.90; or $8.95 per prescription.	Deductible: $0 *Copayment/Coinsurance* during the Initial Coverage Stage: For generic drugs (including brand drugs treated as generic), either $0.00; or $1.30; or $3.70 per prescription. For all other drugs, either $0.00; or $4.00; or $9.20 per prescription.
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 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.	$7,550 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.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (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	2020 (this year)	2021 (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) 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	$7,550 Once you have paid $7,550 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 Directory is located on our website at www.aetnabetterhealth.com/virginia-hmosnp/find-provider. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*.

Please review the 2021 Provider 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, we must 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 to manage 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network has changed more than usual for 2021. An updated Pharmacy Directory is located on our website at www.aetnabetterhealth.com/virginia-hmosnp/find-provider. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **We strongly suggest that you review our current Pharmacy Directory to see if your pharmacy is still in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* 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,

Benefits Chart (what is covered), in your *2021 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at www.aetnabetterhealth.com/virginia-hmosnp. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Additional telehealth services	Additional telehealth services are not covered.	You pay 0% of the total cost for each service.
Help during a COVID-19 public health emergency	During the COVID-19 public health emergency, we offered temporarily expanded coverage, including broad coverage of telehealth services, zero dollar telehealth visits, PCP visits, and inpatient COVID testing.	If a COVID-19 public health emergency is in effect, members have additional coverage to help ensure care continuity and provide care in the home when appropriate. If a declaration is in effect, please reach out to Member Services at the number on the back of your ID card for more information.
Over-the-Counter (OTC) items	Plan provides an allowance of $60 every month for Over-the-Counter (OTC) medications and supplies which can be ordered through a catalog. You may place one order each month and are limited to up to five (5) like items per month, with the exception of Blood Pressure Monitors, which are limited to one per year. Orders cannot exceed your monthly allowance.	Plan provides an allowance of $55 every month for Over-the-Counter (OTC) medications and supplies which can be ordered through a catalog or select participating CVS locations. Please visit www.cvs.com/otchs/myorder and log into your account to view your catalog of Over-the-Counter (OTC) items available to you. You may place one order each month and are limited to up to three (3) like items per month, with the exception of Blood Pressure Monitors, which are limited to one per year. Orders cannot exceed your monthly allowance.

Cost	2020 (this year)	2021 (next year)
Podiatry services (additional)	You pay 20% of the total cost for each non-Medicare-covered service (three visits every year).	You pay a $0 copay for each non-Medicare covered service (three visits every year).
Transportation services (non-emergency)	You pay 0% of the total cost for each non-Medicare-covered service (60 one-way trips every year). Transportation services (non-emergency) are provided by Logisticare.	You pay 0% of the total cost for each non-Medicare-covered service (24 one-way trips every year). Transportation services (non-emergency) are provided by Logisticare.

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 provided electronically.

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 Member Services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services 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. 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 Member Services 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* which is located on our website at www.aetnabetterhealth.com/virginia-hmosnp. 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, 2021, 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 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* which is located on our website at www.aetnabetterhealth.com/virginia-hmosnp, if you need to continue on the current drug.

Important Note: Please take action 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* which is located on our website at www.aetnabetterhealth.com/virginia-hmosnp. 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.
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 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. Because you receive "Extra Help" and haven't received this insert by September 30th, please call Member Services and ask for the "LIS Rider."

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	2020 (this year)	2021 (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

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	2020 (this year)	2021 (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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: • For generic drugs (including brand drugs treated as generic), you pay either $0.00; or $1.30; or $3.60 per prescription. • For all other drugs, either $0.00; or $3.90; or $8.95 per prescription.	Your cost for a one-month supply at a network pharmacy: • For generic drugs (including brand drugs treated as generic) from a pharmacy in our Preferred Network, Tier 1 and Tier 2 drugs are $0.00, for Tiers 3-5, you pay either $0.00; or $1.30; or $3.70 per prescription. • For all other drugs, either $0.00; or $4.00; or $9.20 per prescription. • For generic drugs (including brand drugs treated as generic) from a pharmacy in our Standard Pharmacy Network, you pay either $0.00; or $1.30; or $3.70 per prescription. • For all other drugs, either $0.00; or $4.00; or $9.20 per prescription. OR • Drug Tier 1: $5 • Drug Tier 2: $10 • Drug Tier 3: 25% • Drug Tier 4: 35% • Drug Tier 5: 29%

Stage	2020 (this year)	2021 (next year)
We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Aetna Better Health of Virginia (HMO D-SNP)

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 by December 7, you will automatically be enrolled in our Aetna Better Health of Virginia (HMO D-SNP).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 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.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, COVENTRY HEALTH CARE OF VIRGINIA, INC. offers other Medicare health 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 Aetna Better Health of Virginia (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Aetna Better Health of Virginia (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 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 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from October 15 to December 7. The change will take effect on January 1, 2021.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2021, 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, 2021. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 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.

SHIP 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. *SHIP* 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 *SHIP* at the phone number in **Addendum A** at the back of the *Evidence of Coverage*.

For questions about your Medicaid benefits, contact Medicaid. The name and phone numbers for this organization are in the **Addendum A** at the back of the *Evidence of Coverage.* Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are probably enrolled in "Extra Help", also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because 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).
- **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 ADAP for your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP for your state (the name and phone numbers for this organization are in the **Addendum A** at the back of the *Evidence of Coverage*).

SECTION 6 Questions?

Section 6.1 – Getting Help from Aetna Better Health of Virginia (HMO D-SNP)

Questions? We're here to help. Please contact our Member Services 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. Calls to these numbers are free.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for *Aetna Better Health of Virginia (HMO D-SNP).* 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* is located on our website at www.aetnabetterhealth.com/virginia-hmosnp. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 6.2 – 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 (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 www.medicare.gov/plan-compare).

Read *Medicare & You 2021*

You can read *Medicare & You 2021* 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 (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 6.3 – Getting Help from Medicaid

To get information from Medicaid, you can contact the Medicaid agency for your state (the name and phone numbers for this organization are in the **Addendum A** at the back of the *Evidence of Coverage*).

See the *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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

Aetna Better Health of Virginia's pharmacy network includes limited lower cost, preferred pharmacies in: Rural Nebraska, Rural Kansas, Suburban West Virginia, Rural Maine, Suburban Arizona, Rural Michigan, and Urban Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call the number on your ID card (TTY: 711) or consult the online pharmacy directory at www.aetnabetterhealth.com/virginia-hmosnp/find-provider.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website at or call the phone number listed in this material.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe that Aetna Better Health of Virginia has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Aetna Better Health of Virginia Medicare Appeals and Grievances, PO Box 818070, Cleveland, OH 44181. You can also file a grievance by phone by calling the phone number on your member identification card (TTY: 711). If you need help filing a grievance, the Aetna Better Health of Virginia Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

繁體中文（**CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。