aetna

CardinalCare
Virginia's Medicaid Program
Medicare and Medicaid Working Together

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

Annual Notice of Changes for 2025

You are currently enrolled as a member of Aetna Better Health of Virginia (HMO D-SNP). Next year, there will be changes to the plan's benefits. ***Please see page 6 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about benefits or rules please review the *Evidence of Coverage*, which is located on our website at AetnaBetterHealth.com/Virginia-hmosnp. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

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

- Review the changes to our drug coverage, including coverage restrictions.
- Check the changes in the 2025 Drug List to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in Aetna Medicare Better Health (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Aetna Medicare Better Health (HMO D-SNP).
- Look in Section 4.2, page 15 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.
- Starting January 1, 2025, when you choose a DSNP plan your Medicare and Medicaid plans will be combined into one plan, and the Medicare D-SNP plan you choose will also be your Medicaid plan.
- D-SNP members receiving full Medicaid benefits, who want to choose a different plan, may use a Special Enrollment Period, or SEP, which will allow you to change plans outside of the annual and open enrollment period. You can elect to use the monthly SEP to switch to an aligned plan, or to disenroll from the D-SNP and return to Original Medicare plus a Part D plan.

Additional Resources

- This document is available for free in Spanish. Este documento está disponible sin cargo en español.
- This document is available for free in Chinese. 本文件免費提供中文版本。
- This document is available for free in Tagalog. Ang dokumentong ito ay makukuha nang libre sa Tagalog.
- This document is available for free in French. Ce document est disponible gratuitement en français.
- This document is available for free in Vietnamese. Tài liệu này có sẵn miễn phí bằng Tiếng Việt.
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- This document is available for free in Hawaiian. Loa‘a kēia palapala manuahi i ka ‘ōlelo Hawai‘i.
- This document is available for free in Amharic. ይህ ሰነድ በአማርኛ ቋንቋ በነጻ ይገኛል.
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دا سند په پښتو ژبه کې په وړیا توګه موجود دي.
- This document is available for free in Telugu. ఈ డాక్యుమెంట్ తెలుగులో ఉచితంగా లభిస్తుంది.
- This document is available for free in Nepali. यो कागजात नेपाली भाषामा नि:शुल्क उपलब्ध छ.
- This document is available for free in Bengali. এই নথিটি বাংলা ভাষায় বিনামূল্যে উপলব্ধ আছে.
- This document is available for free in Igbo. Akwụkwọ a dị n'efu n'asụsụ Igbo.
- Please contact our Member Services number at 1-855-463-0933 or the number on your member ID card for additional information. (TTY users should call 711.) Hours are 8 AM to 8 PM, 7 days a week. This call is free.
- This document is available in other formats such as braille, large print or other alternate formats upon request.
- **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 Medicare Better Health (HMO D-SNP)

- Aetna Medicare Better Health (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan with a Medicare contract and a contract with the Virginia Medicaid program. Enrollment in Aetna Medicare Better Health depends on contract renewal.
- When this document says “we,” “us," or “our,” it means COVENTRY HEALTH CARE OF VIRGINIA, INC. When it says “plan” or “our plan,” it means Aetna Medicare Better Health (HMO D-SNP).

Annual Notice of Changes for 2025

Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Aetna Medicare Better Health (HMO D-SNP) in several important areas.

Please note this is only a summary of costs.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium	$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	$0 copay per stay	$0 copay per stay
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible $0 Copayment/Coinsurance during the Initial Coverage Stage: For covered generic drugs (including brand drugs treated as generic), $0 per prescription. For all other covered drugs, $0 per prescription.	Deductible $0 Copayment/Coinsurance during the Initial Coverage Stage: For covered generic drugs (including brand drugs treated as generic), $0 per prescription. For all other covered drugs, $0 per prescription.
	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered services. (See Section 2.2 for details.)	$8,850 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.	$9,350 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.

SECTION 1 We Are Changing the Plan's Name

On January 1, 2025, our plan name will change from Aetna Better Health of Virginia (HMO D-SNP) to Aetna Medicare Better Health (HMO D-SNP). The new plan name will appear on all of our plan documents and letters. We may mail you a new member ID card as a result of this change. If you do receive a new card, please begin using it starting January 1, 2025.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (Your Medicare Part B premium is paid for you by Medicaid.)	$0	$0

Section 2.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for 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	2024 (this year)	2025 (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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,850	$9,350 Once you have paid $9,350 out of pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 Changes to the Provider and Pharmacy Networks

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.

Updated directories are located on our website at AetnaBetterHealth.com/Virginia-hmosnp/find-provider. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider & Pharmacy Directory* AetnaBetterHealth.com/Virginia-hmosnp/find-provider to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Provider & Pharmacy Directory* AetnaBetterHealth.com/Virginia-hmosnp/find-provider to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 Changes to Benefits for Medical Services

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

We are making changes to benefits for certain medical services next year. The information below describes these changes.

Benefit	2024 (this year)	2025 (next year)
Dental services (additional)	Additional (non-Medicare covered) dental services maximum benefit: Plan pays $3,000 every year for additional (non-Medicare covered) comprehensive dental services. Additional (non-Medicare covered) dental services are provided by DentaQuest. See the *Evidence of Coverage* for more information. Preventive dental services (non-Medicare covered): • Oral exams: Not covered • X-rays: $0 copay • Other diagnostic dental services: $0 copay • Cleanings: Not covered • Fluoride treatments: Not covered • Other preventive dental services: $0 copay Comprehensive dental services (non-Medicare covered): • Restorative services: $0 copay • Endodontics: $0 copay • Periodontics: $0 copay • Prosthodontics, removable: $0 copay • Maxillofacial prosthetics: $0 copay • Implant services: $0 copay • Prosthodontics, fixed: $0 copay • Oral and maxillofacial surgery: $0 copay • Orthodontics: $0 copay • Adjunctive general services: $0 copay Additional coverage available through your Medicaid benefits. See the dental schedule in the Evidence of Coverage for additional details.	Additional (non-Medicare covered) dental services maximum benefit: Plan pays $3,000 every year for additional (non-Medicare covered) preventive dental services and additional (non-Medicare covered) comprehensive dental services combined. Additional (non-Medicare covered) dental services are provided by DentaQuest. See the *Evidence of Coverage* for more information. Preventive dental services (non-Medicare covered): • Oral exams: Not covered • X-rays: $0 copay • Other diagnostic dental services: $0 copay • Cleanings: Not covered • Fluoride treatments: Not covered • Other preventive dental services: $0 copay Comprehensive dental services (non-Medicare covered): • Restorative services: $0 copay • Endodontics: $0 copay • Periodontics: $0 copay • Prosthodontics, removable: $0 copay • Maxillofacial prosthetics: Not covered • Implant services: $0 copay • Prosthodontics, fixed: $0 copay • Oral and maxillofacial surgery: $0 copay • Orthodontics: $0 copay • Adjunctive general services: $0 copay Additional coverage available through your Medicaid benefits. See the dental schedule in the Evidence of Coverage for additional details.

Benefit	2024 (this year)	2025 (next year)
Extra Supports Wallet	By qualifying for enrollment in this plan, you get an Extra Supports Wallet on an Aetna Medicare Extra Benefits Card to help you pay for everyday expenses. See the *Evidence of Coverage* for more information and eligibility requirements. **Extra Supports Wallet** $375 monthly benefit amount (allowance) to pay for: • Healthy foods including meat, produce, dairy products, and more • Over-the-counter (OTC) approved health and wellness products including allergy medicine, pain relievers, first aid supplies, and more • Transportation including gas at the pump, public transportation, and certain ride share services • Utilities including gas, electric, water, sewer, landline, cell phone, and internet service • Personal care products including paper towels, shampoo, soap, and more • Pet supplies including food, toys, and grooming supplies • Rent or mortgage assistance Be sure to use the full allowance each month, because any unused allowance will not roll over into the next month. See the *Evidence of Coverage* for more information.	By qualifying for enrollment in this plan, you get an Extra Supports Wallet on an Aetna Medicare Extra Benefits Card to help you pay for everyday expenses. See the *Evidence of Coverage* for more information and eligibility requirements. **Extra Supports Wallet** $350 monthly benefit amount (allowance) to pay for: • Healthy foods including meat, produce, dairy products, and more • Over-the-counter (OTC) approved health and wellness products including allergy medicine, pain relievers, first aid supplies, and more • Transportation including gas at the pump, public transportation, and certain ride share services • Utilities including gas, electric, water, sewer, landline, cell phone, and internet service • Personal care products including paper towels, shampoo, soap, and more Be sure to use the full allowance each month, because any unused allowance will not roll over into the next month. See the *Evidence of Coverage* for more information.

Benefit	2024 (this year)	2025 (next year)
Eyewear — prescription (non-Medicare covered)	Non-Medicare covered eyewear maximum benefit: Plan pays $500 every year for non-Medicare covered prescription eyewear. Covered prescription eyewear: • Contact lenses: $0 copay • Eyeglasses (lenses and frames): $0 copay • Eyeglass lenses: $0 copay • Eyeglass frames: $0 copay • Upgrades (including UV protection and scratch coating): $0 copay Non-Medicare covered eyewear services are provided by VSP. See the *Evidence of Coverage* for more information.	Our plan pays $250 every year for prescription glasses or contacts. You must use the VSP network.
Hearing aids	Hearing aid maximum benefit allowance: Plan pays $2,500 per ear for hearing aids every year. Hearing aids: $0 copay per ear, per year (two hearing aids every year). Hearing aids are provided by NationsHearing. See the *Evidence of Coverage* for more information.	Plan pays $1,500 for hearing aids plus 60 batteries per year. Hearing aids must be purchased through Nations Hearing.
Meal benefit (post-discharge)	You pay a $0 copay for 14 meals over a 7-day period after discharge from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility. See the *Evidence of Coverage* for more information. Meals are provided by Mom's Meals.	You pay a $0 copay for up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital. Meals are provided by Mom's Meals.
Medicare Part B prescription drugs (all other drugs covered under Part B)	Our Part B step program categories and targeted drugs may change yearly. Please visit the following link to review our list of Medicare Part B drugs that may be subject to step therapy: AetnaBetterHealth.com/Virginia-hmosnp/providers/hmo-snp-pr/snp-prescriptions. See the *Evidence of Coverage* for more information.	Our Part B step program categories and targeted drugs may change yearly. Please visit the following link to review our list of Medicare Part B drugs that may be subject to step therapy: AetnaBetterHealth.com/Virginia-hmosnp/providers/hmo-snp-pr/snp-prescriptions. See the *Evidence of Coverage* for more information.

Benefit	2024 (this year)	2025 (next year)
Outpatient hospital observation services	You pay a $0 copay for each Medicare-covered service. Prior authorization is not required.	You pay a $0 copay for each Medicare-covered service. Prior authorization may be required.

Section 2.5 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, which could include removing or adding drugs or changing 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.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan 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 your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately add new restrictions.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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 does 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" if

you haven't received this insert by September 30th, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the 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 do not count toward out-of-pocket costs.

Changes to your VBID Part D Benefit

Because you qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you are eligible for the following cost shares through the Aetna Rx Cost Support Program:

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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

Stage	2024 (this year)	2025 (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.** For information about the costs for a long-term supply, look in Chapter 5, Sections 2.3 and 2.4 of your *Evidence of Coverage*.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: You pay $0 for covered Part D drugs.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: You pay $0 for covered Part D drugs.
Most adult Part D vaccines are covered at no cost to you.	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6 in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Description	2024 (this year)	2025 (next year)
How to obtain OneTouch/LifeScan blood glucose monitors and test strips	You can order your OneTouch meter, lancing device, and case without a prescription by visiting www.OneTouch.orderpoints.com or calling LifeScan directly at 877-764-5390. You will need to provide order code 123AET200 at the time of your order.	Beginning January 2025, you must obtain a prescription from your provider for your LifeScan blood glucose meter and other testing supplies (lancing devices, lancets, and test strips). You must obtain these supplies directly from a network pharmacy. Meters and supplies will no longer be available directly from LifeScan.

SECTION 4 Deciding Which Plan to Choose

Section 4.1	If you want to stay in Aetna Medicare Better Health (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 Medicare Better Health (HMO D-SNP).

Section 4.2	If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 7.2).

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 Medicare Better Health (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 Medicare Better Health (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 so.
  - –*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 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

Are there other times of the year to make a change?
In certain situations, changes are also allowed at other times of the year. Examples include 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.

Because you have Cardinal Care, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage Plan for January 1, 2025, and don't like your plan choice, you can also 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Starting January 1, 2025, when you choose a DSNP plan your Medicare and Medicaid plans will be combined into one plan, and the Medicare D-SNP plan you choose will also be your Medicaid plan.

D-SNP members receiving full Medicaid benefits, who want to choose a different plan, may use a Special Enrollment Period, or SEP, which will allow you to change plans outside of the annual and open enrollment period. You can elect to use the monthly SEP to switch to an aligned plan, or to disenroll from the D-SNP and return to Original Medicare plus a Part D plan.

SECTION 6 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state.

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 below.

	State Health Insurance Assistance Program (SHIP)
Virginia	**Virginia Insurance Counseling and Assistance Program (VICAP)**, **Address:** Division for Aging Services, 1610 Forest Ave., Suite 100, Henrico, Virginia 23229, **Phone:** 1-800-552-3402, 804-662-9333, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** vda.virginia.gov/vicap.htm

For questions about your Medicaid benefits, contact Medicaid. The name and phone numbers for this organization are below. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

	State Medicaid Office
Virginia	**Virginia Medicaid**, **Address:** Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, **Phone:** 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), **TTY:** 1-888-221-1590 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, **Website:** dmas.virginia.gov/ Questions can also be submitted online at ask.vamedicaid.dmas.virginia.gov/ask-va-medicaid#/. This is Virginia Medicaid's online request portal. That website also provides answers to frequently asked questions about Virginia Medicaid.

SECTION 7 Questions?

Section 7.1	Getting Help from Aetna Medicare Better Health (HMO D-SNP)

Questions? We're here to help. Please call Member Services at 1-855-463-0933 or the number on your member ID card (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 2025 *Evidence of Coverage* (it has details about next year's benefits)
This *Annual Notice of Changes* gives you a summary of changes in your benefits for 2025. For details, look in the *2025 Evidence of Coverage* for Aetna Medicare Better Health (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 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 AetnaBetterHealth.com/Virginia-hmosnp. As a reminder, our website has the most up-to-date information about our provider network (*Provider and 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
Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*
Read the *Medicare & You 2025* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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 Cardinal Care, you can call Cardinal Care (the name and phone numbers for this organization are below).

	State Medicaid Office
Virginia	**Virginia Medicaid**, **Address:** Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, **Phone:** 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), **TTY:** 1-888-221-1590 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, **Website:** dmas.virginia.gov/ Questions can also be submitted online at ask.vamedicaid.dmas.virginia.gov/ask-va-medicaid#/. This is Virginia Medicaid's online request portal. That website also provides answers to frequently asked questions about Virginia Medicaid.

See *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 and/or pharmacy network may change at any time. You will receive notice when necessary.

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

For mail order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call 1-855-463-0933 (TTY: 711) 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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 does 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, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, our 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. Our health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, visit our website, call the phone number listed in this material or on your benefit ID card.

If you believe that we have 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 our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

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.

How we guard your privacy

What personal information is — and what it isn't
By "personal information," we mean information that can be used to identify you. It can include financial and health information. It doesn't include what the public can easily see. For example, anyone can look at what your plan covers.

How we get information about you
We get information about you from many sources, including you. We also get information from your employer, other insurers, or health care providers like doctors.

When information is wrong
Do you think there's something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal. Information on how to file an appeal is on our member website. Or you can call the toll-free number on your ID card.

How we use this information
When the law allows us, we use your personal information both inside and outside our company. The law says we don't need to get your OK when we do. We may use it for your health care or use it to run our plans. We also may use your information when we pay claims or work with other insurers to pay claims. We may use it to make plan decisions, to do audits, or to study the quality of our work. This means we may share your information with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices, or third-party administrators. But by law, all these parties must keep your information private.

When we need your permission
There are times when we do need your permission to disclose personal information. This is explained in our Notice of Privacy Practices, which took effect October 10, 2020. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers' compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

To get a copy of this notice, just visit our member website or call the toll-free number on your ID card.

Form Approved
OMB#0938-1421

Multi-Language Insert
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-463-0933. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-463-0933. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-463-0933。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-463-0933。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-463-0933. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-463-0933. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-463-0933. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-463-0933. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-463-0933. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-463-0933. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-463-0933 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-463-0933. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-463-0933. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-463-0933. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-463-0933. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-463-0933. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-463-0933. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-855-463-0933. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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Form CMS-10802
(Expires 12/31/25)

Multi-Language Insert
Multi-language Interpreter Services
Additional Languages

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-463-0933. Someone who speaks English can help you. This is a free service.

Amharic: የጤና ወይም የመድኃኒት ዕቅዳችንን በሚመለከት ሊኖርዎ ስለሚችል ማንኛውም ጥያቄዎች መልስ ለመስጠት ነፃ የአስተርጓሚ አገልግሎት አለን። አስተርጓሚ ለማግኘት፣ ይደውሉልን በ 1-855-463-0933 ። አማርኛ መናገር የምችል ሰው እርስዎን መርዳት ይችላል ይህ ነፃ አገልግሎት ነው።

Urdu: ہمارے ہیلتھ یا ڈرگ پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت ترجمان کی خدمات ہیں۔ مترجم حاصل کرنے کے لیے بس ہمیں کال کریں 1-855-463-0933 ۔ کوئی جو بولتا ہے اردو آپ کی مدد کر سکتے ہیں. یہ ایک مفت سروس ہے۔

Farsi (Persian): ما خدمات مترجم شفاهی رایگان داریم تا به هر سؤالی که ممکن است در مورد طرح سلامت یا داروی خود داشته باشید، پاسخ دهیم. برای دسترسی به مترجم شفاهی، فقط با شماره 1-855-463-0933 . تماس بگیرید. کسی که حرف به زبان فارسی حرف میزند میتواند به شما کمک کند. این خدمات رایگان است.

Dari: ما خدمات رایگان ترجمان داریم تا به هر سوال که شما ممکن است در مورد طرح صحت یا دوای خود داشته باشید جواب دهیم. برای دریافت ترجمان صرف با شماره 1-855-463-0933 . با ما تماس بگیرید. کسی که به دری صحبت میکند، میتواند به شما کمک کند. این یک خدمت رایگان است.

Pashto: مورږ د ژباړونکي وړیا خدمتونه لرو ترڅو زمورږ د روغتیا یا درملو پلان په اړه هری پوښتنې ته ځواب ووایي. د ژباړونکي ترلاسه کولو لپاره مورږ ته په 1-855-463-0933 شمېری زنګ ووهئ. هغه ځوک چې په پښتو خبرې کوی کولای شی چې له تاسو سره مرسته وکړي. دا یو وړیا خدمت دی.

Telugu: మా ఆరోగ్యం మరియు ఔషధ ప్రణాళిక గురించి మీకు ఏవైనా ప్రశ్నలు ఉంటే సమాధానం ఇవ్వడానికి మా వద్ద ఉచిత వ్యాఖ్యాత సేవలు ఉన్నాయి. వ్యాఖ్యాతను పొందడానికి మాకు ఇక్కడ కాల్ చేయండి 1-855-463-0933. ఆ భాష మాట్లాడే ఎవరో ఒకరు మీకు సహాయం చేయవచ్చు. ఇది ఉచిత సేవ.

Nepali: हाम्रो स्वास्थ्य वा औषधि योजनाको बारेमा तपाईंमा हुन सक्ने कुनै पनि प्रश्नहरूको जवाफ दिन हामीसँग नि: शुल्क अनुवाद सेवाहरू छन्। दोभाषे प्राप्त गर्न केवल हामीलाई यहाँ फोन गर्नुहोस् 1-855-463-0933। नेपाली भाषा बोल्नेले तपाईंलाइ मद्दत गर्न सक्छ। यो नि: शुल्क सेवा हो।

Bengali: আমাদের স্বাস্থ্য কিংবা ঔষধের পরিকল্পনা সম্পর্কে আপনার যেকোনো প্রশ্নের উত্তর দেওয়ার জন্য আমরা বিনামূল্যে অনুবাদক পরিষেবা প্রদান করে থাকি। একজন অনুবাদক পাওয়ার জন্য কেবল 1-855-463-0933. নম্বরে ফোন করুন। বাংলা ভাষায় কথা বলে এমন কেউ আপনাকে সাহায্য করতে পারেন। এই পরিষেবার জন্য আপনাকে কোনো অর্থ প্রদান করতে হবে না।

Igbo: Anyị nwere ọrụ onye nsụgharị n'efu ga-aza ajụjụ ịnwere ike inwe gbasara atụmatụ ahụike na ọgwụ anyị. Iji nweta onye nsụgharị naanị kpọọ anyị na 1-855-463-0933. Onye na-asụ Igbo ga-enyere gị aka. Nke a bụ ọrụ n'efu.

aetna

CardinalCare
Virginia's Medicaid Program
Medicare and Medicaid Working Together

Aetna Medicare Better Health (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL	1-855-463-0933 or the number on your member ID card. Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
WRITE	Aetna Better Health of Virginia Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	Go to AetnaBetterHealth.com/Virginia-hmosnp or scan this code with your smartphone to visit our website.

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