



Coventry Medicare Advantage (PPO) offered by Coventry Health Care, part of the Aetna family

Annual Notice of Changes for 2016

You are currently enrolled as a member of *Coventry Medicare Advantage (PPO)*. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You may make a change during the annual enrollment period offered by your Employer Group, Union or Benefit Trust.**
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Additional Resources

- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1).
- This document may be made available in other formats such as Braille, large print or other alternate formats

About Coventry Medicare Advantage (PPO)

- Aetna Medicare is a PDP, 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 & Life Insurance Company*. When it says "plan" or "our plan," it means *Coventry Medicare Advantage (PPO)*.

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 2.5 and 2.6 for information about benefit and cost changes for our plan.
- Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 2.6 for information about changes to our drug coverage.
- 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 2.3 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? How do the total costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.**

If you decide to stay with your Employer Group's plan:

If you want to stay with us next year, it's easy - you don't need to do anything. If you don't make a change during the annual enrollment period offered by your Employer Group, Union or Benefit Trust, you will automatically stay enrolled in our plan.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch during the annual enrollment period offered by your Employer Group, Union or Benefit Trust. If you enroll in a new plan, your new coverage will begin on the effective date established by your Employer Group, Union or Benefit Trust. Look in Section 4.2 to learn more about your choices.

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 costs for *your Employer Group's 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 *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2015 (this year)	2016 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	\$188 <i>Please contact your benefits office for information on your premium. In addition, you must continue to pay your monthly Medicare Part B premium.</i>	\$156 <i>Please contact your benefits office for information on your premium. In addition, you must continue to pay your monthly Medicare Part B premium</i>
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	\$1,000	\$1,000

Cost	2015 (this year)	2016 (next year)
<p>Doctor office visits</p>	<p>Primary care visits: \$10 per visit</p> <p>Specialist visits: \$25 per visit</p>	<p>Primary care visits: \$10 per visit</p> <p>Specialist visits: \$25 per visit</p>
<p>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.</p>	<p>Days 1-5: \$150 copay per day;</p>	<p>Days 1-5: \$150 copay per day; in and out- of - Network</p>
<p>Part D prescription drug coverage (See Section 2.6 for details.)</p>	<p>Standard Retail cost share during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$5 • Drug Tier 2: \$10 • Drug Tier 3: \$45 • Drug Tier 4: 50% • Drug Tier 5: 33% 	<p>Standard Retail cost share during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$5 • Drug Tier 2: \$10 • Drug Tier 3: \$45 • Drug Tier 4: 50% • Drug Tier 5: 33%

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in your Employer Group's plan in 2016

If you do nothing to change your Medicare coverage by the end of your Employer Group, Union or Benefit Trust enrollment plan, we will automatically enroll you in your Employer Group's plan. This means starting at the beginning of your benefit year, you will be getting your medical and prescription drug coverage through Coventry Medicare Advantage (PPO). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you must do so between October 15 and December 7.

The information in this document tells you about the differences between your current benefits in your Employer Group, Union or Benefit Trust plan and the benefits you will have on your Employer Group, Union or Benefit Trust plan's new benefit year.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2015 (this year)	2016 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$188	\$156
	Please contact your benefits office for information on your premium. In addition, you must continue to pay your monthly Medicare Part B premium.	Please contact your benefits office for information on your premium. In addition, you must continue to pay your monthly Medicare Part B premium.

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.

- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs.

Section 2.2 – 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	2015 (this year)	2016 (next year)
<p>Maximum In-network out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays or deductibles if applicable) count toward your maximum out-of-pocket amount.</p> <p>Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	\$1,000	<p>\$1,000</p> <p>Once you have paid \$1,000 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.</p>
<p>Combined maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays and deductibles (if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.</p> <p>Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	\$10,000	<p>\$4,100</p> <p>Once you have paid \$4,100 out-of-pocket for covered services, you will pay nothing for your covered services combined in and out-of-network services for the rest of the calendar year.</p>

Section 2.3 – 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 <http://providerdirectory.coventry-medicare.com>. You may also call Customer Service for updated provider information or to ask us to mail you a Provider & Pharmacy Directory.

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.
- When possible we will 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 2.4 – 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 pharmacies within the network.

Our network has changed more than usual for 2016

An updated Provider & Pharmacy Directory is located on our website at <http://providerdirectory.coventry-medicare.com>. You may also call Customer Service for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. **We strongly suggest that you review the 2016 Provider & Pharmacy Directory to see if your pharmacy is still in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

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 2016 Evidence of Coverage.

Cost	2015 (this year)	2016 (next year)
<i>Skilled Nursing Facility (SNF)</i>	You pay a \$156.50 copay per day for days 21-100	You pay a \$160.00 copay per day for days 21-100
<i>Mental Health Care</i>	You pay 20% of the total cost for Out-of-Network	You pay a \$150.00 copay per day for days 1-5 for In and Out-of-Network
<i>Inpatient Hospital Care</i>	You pay 20% of the total cost for Out-of-Network	You pay a \$150.00 copay per day for days 1-5 for In and Out-of-Network
<i>Outpatient Surgery(Ambulatory Surgical Center)</i>	You pay 20% of the total cost for Out-of-Network	You pay a \$150.00 copay for In and Out-of-Network
<i>Outpatient Surgery(Outpatient Hospital)</i>	You pay 20% of the total cost for Out-of-Network	You pay a \$150.00 copay for In and Out-of-Network

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to basic rules for the plan's Part D drug coverage

Effective June 1, 2016, before your drugs can be covered under the Part D benefit, CMS will require your doctors and other prescribers to either accept Medicare or to file documentation with CMS showing that they are qualified to write prescriptions.

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. **We encourage current members** to ask for an exception before next year. Current members can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, you'll be able to get your drug at the start of the new plan year.
 - 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 other 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 **one-time**, temporary supply of a non-formulary in the first 90 days of coverage of the plan year or coverage. (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.

Exception requests that were approved in 2015 do not carry over into 2016. If you were granted a formulary exception in 2015, you must request a new formulary exception for 2016. If you do not request a new formulary exception prior to January 1, 2016, the following transition process will apply:

- For currently enrolled members who do not request an exception before January 1, 2016, we will cover up to a 30-day temporary supply (unless your prescription is written for fewer days, in which case we will allow multiple fills to provide up to a total of a 30-day supply) of the drug for the first 90 days of the new plan year starting on January 1st. This will give you time to discuss options with your prescribing physician regarding alternative drugs or requesting an exception if your current drug is not on the formulary next year or has new restrictions.
- For currently enrolled members who are residents in a long-term care facility and do not request an exception before January 1, 2016, we will cover up to a 31-day temporary supply (unless your prescription is written for fewer days, in which case we will allow multiple fills to provide up to a total of a 31-day supply) of the drug for the first 90 days of the new plan

year starting on January 1st. This will give you time to discuss options with your prescribing physician regarding alternative drugs or requesting an exception.

- Currently enrolled members who are changing from one treatment setting to another such as:
 - Members who are discharged from a hospital or skilled nursing facility to a home setting.
 - Members who are admitted to a hospital or skilled nursing facility from a home setting.
 - Members who transfer from one skilled nursing facility to another and are served by a different pharmacy.
 - Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to now use their Part D plan benefit.
 - Members who give up hospice status and revert back to standard Medicare Part A and B coverage.
 - Members discharged from chronic psychiatric hospitals with highly individualized drug regimens.

If you experience a change in treatment setting as described above and a drug therapy is not on the formulary or covered with restrictions, we will cover a 31-day temporary supply if you have not already received a temporary supply in a long term care setting and a 30-day temporary supply for a retail setting.

Regardless of why you received a temporary supply, you will need to utilize our exception process, as defined in the *Evidence of Coverage* that was attached with this Annual Notice of Changes, 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 the effective date of your plan**. 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 was attached to this Annual Notice of Changes. Look for Chapter 9 of the Evidence of Coverage (What to do if you have a problem or complaint).

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 have 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 get “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 8.1 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 at Chapter 6, Sections 6 and 7, in the attached *Evidence of Coverage*.)

In addition to the changes in costs described below, there is a change to daily cost sharing that might affect your costs in the Initial Coverage Stage. Starting in 2016, when your doctor first prescribes less than a full month’s supply of certain drugs, you may no longer need to pay the copay for a full month. (For more information about daily cost sharing, look at Chapter 6, Section 5.3, in the enclosed Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2015 (this year)	2016 (next year)
<p>Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible.</p>	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	2015 (this year)	2016 (next year)
<p>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.</p>	<p>Your cost for a one-month supply filled at a network pharmacy:</p> <p>Tier 1 Preferred Generic:</p> <p><i>Standard cost-sharing:</i> You pay \$5 per prescription</p>	<p>Your cost for a one-month supply filled at a network pharmacy:</p> <p>Tier 1 Preferred Generic:</p> <p><i>Standard cost-sharing:</i> You pay \$5 per</p>

	<p><i>Preferred cost-sharing:</i> You pay \$0 per prescription</p>	<p>prescription</p> <p><i>Preferred cost-sharing:</i> You pay \$0 per prescription</p>
	<p>Tier 2 Generic Drugs:</p> <p><i>Standard cost-sharing:</i> You pay \$10 per prescription</p> <p><i>Preferred cost-sharing:</i> You pay \$5 per prescription</p>	<p>Tier 2 Generic Drugs:</p> <p><i>Standard cost-sharing:</i> You pay \$10 per prescription</p> <p><i>Preferred cost-sharing:</i> You pay \$5 per prescription</p>
	<p>Tier 3 Preferred Brand Drugs:</p> <p>Standard cost-sharing: You pay \$45 per prescription</p> <p>Preferred cost-sharing: You pay \$45 per prescription</p>	<p>Tier 3 Preferred Brand Drugs:</p> <p>Standard cost-sharing: You pay \$45 per prescription</p> <p>Preferred cost-sharing: You pay \$45 per prescription</p>
	<p>Tier 4 Non-Preferred Brand:</p> <p>Standard cost-sharing: You pay 50% of the total cost</p> <p>Preferred cost-sharing: You pay 50% of the total cost</p>	<p>Tier 4 Non-Preferred Brand:</p> <p>Standard cost-sharing: You pay 50% of the total cost</p> <p>Preferred cost-sharing: You pay 50% of the total cost</p>
	<p>Tier 5 Specialty Drugs: Standard cost-sharing: You pay 33% of the total cost</p> <p>Preferred cost-sharing:</p>	<p>Tier 5 Specialty Drugs: Standard cost-sharing: You pay 33% of the total cost</p>

	You pay 33% of the total cost	Preferred cost-sharing: You pay 33% of the total cost
<p>The costs are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard or preferred cost-sharing. For information about the costs for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage and your Summary of Benefits</i>.</p> <p>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.</p>	<p>Once your total drug costs have reached \$2,850, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Once your total drug costs have reached \$3,310, you will move to the next stage (the Coverage Gap Stage).</p>

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

SECTION 3 Other Changes

Process	2015 (this year)	2016 (next year)
Prior Authorization	Prior Authorization requirements are listed in your 2015 <i>Evidence of Coverage</i> , Chapter 4 Medical Benefits chart. Your provider is responsible for any prior authorization submissions.	Prior Authorization requirements may have changed for 2016. Your provider is responsible for any prior authorization submissions. See the Medical Benefits chart in Chapter 4 for benefits that require prior authorization.
Network Pharmacies with Preferred Cost Sharing	See your 2015 Provider & Pharmacy Directory for a list of network pharmacies that have preferred cost sharing in your area	Your preferred pharmacies may have changed for 2016. Please refer to your 2016 <i>Provider & Pharmacy Directory</i> , visit our website at http://pharmacylocator.coventry-medicare.com or call Customer Service to verify the network pharmacies that have preferred cost sharing in your area have not changed.
Out-of-Network Pharmacy Temporary Supply	Limited to a 30-day supply	Limited to a 10-day supply
Pharmacy Benefit Manager (PBM)	Express Scripts (ESI) was the administrator for your prescription drugs	CVS Health will be the administrator for your drugs. You will see or hear the CVS Health name.
Coventry Health Care is changing its name to Aetna.	You received information from only Coventry Health Care.	You may receive information from either Coventry Health Care or Aetna.
Plan Name	KSEHP (PPO)	Coventry Advantra Freedom (PPO)

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in your Employer Group’s 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 by December 7, you will automatically stay enrolled as a member of our plan for 2016.

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 for 2016 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, call your State Health Insurance Assistance Program (SHIP), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <http://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, *Coventry Health Care* offers other Medicare health plans *AND/OR* 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 your Employer Group’s plan.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from your Employer Group’s 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 8.1 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.

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, or** during your Employer, Benefit Trust, or Union Open Enrollment period.. The change will take effect on January 1, 2016.

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, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2016, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. For states in your areas, the SHIP information is below.

- In Arkansas, the SHIP is called Senior Health Insurance Information Program (SHIP) (Arkansas SHIIP)
- In Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).
- In Missouri, the SHIP is called Community Leaders Assisting the Insured in Missouri (CLAIM).
- In Oklahoma, the SHIP is called The Senior Health Insurance Counseling Program (SHIP)

State Health Insurance Assistance Programs (SHIPs) are 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 *or* learn more about by visiting their website.

Senior Health Insurance Information Program (SHIP) (Arkansas SHIIP)	
CALL	1 (800) 224 6330
WRITE	Arkansas Insurance Department 1200 W Third St Little Rock, AR 72201
WEBSITE	www.insurance.arkansas.gov/SHIIP.htm

Senior Health Insurance Counseling for Kansas (SHICK)	
CALL	1 (800) 860-5260
WRITE	SHICK Kansas Department of Aging 503 S Kansas Ave Topeka, KS 66603
WEBSITE	http://www.kdads.ks.gov/SHICK/shick_index.html

Community Leaders Assisting the Insured in Missouri (CLAIM)	
CALL	1 (800) 390-3330
WRITE	CLAIM 200 N Keene St Columbia, MO 65201
WEBSITE	http://www.missouricclaim.org

The Senior Health Insurance Counseling Program in Oklahoma (SHIP)	
CALL	1 (800) 763 2828
WRITE	Five Corporate Plaza 3625 NW 56th St, Suite 100 Oklahoma City, Ok 73112
WEBSITE	http://www.ok.gov/oid/Consumers/Information for Seniors/SHIP.html

SECTION 7 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.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, 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 a.m. and 7 p.m., 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.** *Missouri* has a program called *Missouri RX* 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 6 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 AIDS Drug Assistance Program (ADAP) for your.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

AIDS Drug Assistance Program (ADAP)-Kansas	
Kansas Department of Health & Environment – Bureau of Epidemiology and Disease Prevention: Part B/ADAP Director	
CALL	Telephone: 785-368-8218
WRITE	1000 South West Jackson Topeka, Kansas 66612-1274
FAX	785-291-3420
WEBSITE	http://www.kdheks.gov/sti_hiv/ryan_white_care.htm

AIDS Drug Assistance Program (ADAP)-Missouri	
Missouri Department of Health and Senior Services -Prevention and Care Programs, Section of Communicable Disease Prevention: HIV Care Coordinator	
CALL	573-526-6439
WRITE	930 Wildwood Drive Jefferson City, Missouri 65102-0570
FAX	573-751-6447
WEBSITE	http://www.ahirc.org/resource/missouri-aids-drug-assistance-program-adap

AIDS Drug Assistance Program (ADAP)-Oklahoma	
Oklahoma State Department of Health - HIV/STD Service: HDAP Programs Manager	
CALL	405-271-9444
WRITE	1000 N.E. 10th Street Oklahoma City, Oklahoma 73117-1299
FAX	405-271-3412
WEBSITE	http://www.ok.gov/health/Disease, Prevention, Preparedness/HIV STD Service /

AIDS Drug Assistance Program (ADAP)-Arkansas	
Arkansas Department of Health - STI/HIV/Hepatitis C/TB Section: ADAP Coordinator	
CALL	Telephone: 501-661-2862
WRITE	4815 West Markham Street, Slot 33 Little Rock, Arkansas 72205
FAX	501-280-4877
WEBSITE	http://www.healthy.arkansas.gov/programsServices/infectiousDisease/hivStdHepatitisC/Pages/ADAP.aspx

State Pharmaceutical Assistance Program (SPAP)-Missouri	
Missouri RX Plan	
CALL	Telephone: 800-375-1406
WRITE	PO Box 6500 Jefferson City, MO 65102
WEBSITE	http://morx.mo.gov/

SECTION 8 Questions?

Section 8.1 – Getting Help from Coventry Medicare Advantage (PPO)

Questions? We're here to help. Please call Customer Service at (855) 322-7558. (TTY only, call 711). We are available for phone calls 8 am to 8 pm, local time seven (7) days a week, from October 1 – February 14, and 8 am to 8 pm, local time Monday – Friday, from February 15 – September 30. Calls to these numbers are free.

Read your 2016 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 2016. For details, look in the 2016 *Evidence of Coverage and Summary of Benefits* 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 and Summary of Benefits* is included in this envelope.

Visit our Website

You can also visit our website at www.coventry-medicare.com. As a reminder, our website has the most up-to-date information about our provider network (Provider & Pharmacy Directory).

Section 8.2 – 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 (<http://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 <http://www.medicare.gov> and click on “Find health & drug plans”).

Read *Medicare & You 2016*

You can read the *Medicare & You 2016* 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 (<http://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.