

Sentara Community Complete (HMO D-SNP) offered by Sentara Health Plans

Annual Notice of Changes for 2025

You are currently enrolled as a member of Sentara Community Complete (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. **Please see page 5 for a Summary of Important Costs, including Premium.**

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at sentaramedicare.com/documents. 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 and costs to see if they affect you.
 - Review the changes to medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including coverage restrictions and cost sharing.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
 - 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 Sentara Community Complete.
- 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 Sentara Community Complete.
- Look in section 3.2, 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.

Additional Resources

- Please contact our Member Services number at 1-800-927-6048 for additional information. (TTY users should call the Virginia Relay Service at 1-800-828-1120 or 711.) Hours are from October 1 – March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET. From April 1 – September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Outside of these times, our interactive voice response system allows you to obtain information on many topics related to your plan. This call is free.
- This information is available in other formats such as large print and audio.

- **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 Sentara Community Complete

- Sentara Medicare is an HMO D-SNP with a Medicare contract and a contract with the Virginia Medicaid Program to coordinate your Medicaid benefits. Enrollment in Sentara Medicare depends on contract renewal.
- When this document says “we,” “us,” or “our,” it means Sentara Health Plans. When it says “plan” or “our plan,” it means Sentara Community Complete.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Sentara Community Complete in several important areas. **Please note this is only a summary of costs.** If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2024 (this year)	2025 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher than this amount. See Section 1.1 for details.</p>	\$0	\$0
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$0</p> <p>Copayment during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: You pay \$0-\$4.60 copay per prescription • Drug Tier 2: You pay \$0-\$11.20 copay per prescription <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing. • During this payment stage, the plan pays the full cost for your covered Part D drugs. 	<p>Deductible: \$0</p> <p>Copayment during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: You pay \$0-\$4.80 copay per prescription • Drug Tier 2: You pay \$0-\$12.15 copay per prescription <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. • During this payment stage, the plan pays the full cost for your covered Part D drugs

Cost	2024 (this year)	2025 (next year)
	<ul style="list-style-type: none"> You may have cost sharing for drugs that are covered under our enhanced benefit. 	<ul style="list-style-type: none"> You may have cost sharing for drugs that are covered under our enhanced benefit.
<p>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 1.2 for details.)</p>	<p>\$8,850</p> <p>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.</p>	<p>\$9,350</p> <p>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.</p>

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (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

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 Part A and Part B 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 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 Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – 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. 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.

Updated directories are located on our website at sentarahealthplans.com/members/medicare/provider-and-pharmacy-directories. 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 Directory** sentarahealthplans.com/members/medicare/provider-and-pharmacy-directories 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 Pharmacy Directory** sentarahealthplans.com/members/medicare/provider-and-pharmacy-directories 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 a 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 1.4 – 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 making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Barium Enemas	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Diabetes Self-Management Training	Authorization is not required for this benefit.	Authorization may be required for this benefit.

Cost	2024 (this year)	2025 (next year)
Diabetic Supplies (Medicare Covered)	Diabetic test strips limited to 120/month.	Diabetic test strips limited to 90/month.
Digital Rectal Exams	Authorization is not required for this benefit.	Authorization may be required for this benefit.
EKG following Welcome Visit	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Routine Vision: Eyewear Allowance	\$300 allowance	\$400 allowance
Glaucoma Screening	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Grocery Allowance	You have a \$100 allowance every month to spend on plan-approved grocery products. If you do not use all your monthly grocery benefit amount when you order, the remaining balance will not roll over to the next month.	You have a \$350 allowance every month to spend on plan-approved grocery products. If you do not use all your monthly grocery benefit amount when you order, the remaining balance will not roll over to the next month.
In-Home Support Services	You will receive 90 hours of service. Authorization is not required for this benefit.	You will receive 40 hours of service. Authorization may be required for this benefit.
Kidney Disease Education Services	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Medicare-covered Preventive Services	Authorization is not required for this benefit.	Authorization may be required for this benefit.

Cost	2024 (this year)	2025 (next year)
Medicare Diagnostic Hearing Exams	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Medicare Part B Insulin Drugs	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Occupational Therapy Services	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Opioid Treatment Program Services	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Other Health Care Professional	Authorization is not required for this benefit.	Authorization may be required for this benefit.
OTC Items	\$500 Quarterly Allowance	\$200 Quarterly Allowance
Outpatient Blood Services	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Physical Therapy	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Physician Specialist Services	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Podiatry Services (Medicare-covered)	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Podiatry Services (Routine Foot Care)	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Routine Chiropractic Care	Authorization is not required for this benefit.	Authorization may be required for this benefit.
Speech Language Pathology Services	Authorization is not required for this benefit.	Authorization may be required for this benefit.

Cost	2024 (this year)	2025 (next year)
Transportation Services – Plan Approved Health-related Location	48 one-way trips to plan approved health-related locations.	60 one-way trips to plan approved health-related locations.
Value-Based Insurance Design (VBID)-Rewards and Incentives - Medication Therapy Management.	You may receive a \$50 reward for completing your Medication Therapy Management	Not Covered

Section 1.5 – 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. The Drug List includes many—but not all—of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the complete Drug List** by calling Member Services (see the back cover) or visiting our website (sentarahealthplans.com/members/medicare/provider-and-pharmacy-directories).

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes 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 on the same or a lower cost-sharing tier and 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 move it to a different cost-sharing tier or add new restrictions or both

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 may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2024, 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 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)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Your cost for a one-month supply is:</p> <p>Cost-share Tier 1: You pay \$0-\$4.60 Copay per prescription.</p> <p>Cost-share Tier 2: You pay \$0-\$11.20 Copay per prescription.</p> <p>Once you have paid \$8,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p>Your cost for a one-month supply is:</p> <p>Cost-share Tier 1: You pay \$0-\$4.80 Copay per prescription.</p> <p>Cost-share Tier 2: You pay \$0-\$12.15 Copay per prescription.</p> <p>Once you have paid \$2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

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.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have sharing for excluded drugs that are covered under our enhanced benefits.

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

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Member ID Card	As a member of Sentara Medicare Community Complete, you have one ID card for your Medicare benefits and a separate ID card for your Medicaid Benefit.	As a member of Sentara Medicare Community Complete, you will have one ID card for both your Medicare and your Medicaid benefits.
Medicare Prescription Payment Plan	Not applicable	<p>The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).</p> <p>To learn more about this payment option, please contact us at 1-866-845-1803 (TTY: 711) or visit Medicare.gov.</p>

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Sentara Community Complete*

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 Sentara Community Complete.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change 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 5), or call Medicare (see Section 7.2).

As a reminder, Sentara Health Plans 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 Sentara Community Complete.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Sentara Community Complete.
- 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 4 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 Sentara Community Plan 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.

SECTION 5 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. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP) (coordinated through the Virginia Division for the Aging).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. VICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call VICAP at 1-800-552-3402 (TTY 711). You can learn more about VICAP by visiting their website (www.vda.virginia.gov/vicap.htm).

For questions about your Virginia Department of Medical Assistance Services (DMAS) Cardinal Care Managed Care (CCMC) (Medicaid) benefits, contact CCMC Plus at 1-844-374-9159 (TTY 1-800-817-6608) Monday through Friday from 8:30 a.m. until 6:00 p.m. Ask

how joining another plan or returning to Original Medicare affects how you get your CCMC Plus coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **“Extra Help” from Medicare.** Because you have Medicaid, you are already enrolled in “Extra Help,” also called the Low-Income Subsidy. “Extra Help” pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office.

- **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. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Virginia Medication Assistance Program (VA MAP). For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call 1-855-362-0658 (TTY: 711). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn’t save you money or lower your drug costs.**

“Extra Help” from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this

payment option. To learn more about this payment option, please contact us at 1-866-845-1803 (TTY: 711) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Sentara Community Complete

Questions? We're here to help. Please call Member Services at 1-800-927-6048. (TTY only, call the Virginia Relay Service at 1-800-828-1120 or 711.) We are available for phone calls 7 days a week from 8:00 a.m. to 8:00 p.m. ET from October 1 – March 31. From April 1 – September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Outside of these times, our interactive voice response system allows you to obtain information on many topics related to your plan. Calls to these numbers are free.

Read your 2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Sentara Community Complete. 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 sentaramedicare.com/documents. 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 sentarahealthplans.com/members/medicare. 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 Medicaid you can call the Virginia Department of Medical Assistance Services (DMAS) at 1-804-786-7933. TTY users should call 711.