Kaiser Permanente Medicare Plus Basic w/o D (AB) (Cost) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of Kaiser Permanente Medicare Plus Basic w/o D (AB). Next year, there will be some changes to our plan's costs and benefits. This booklet tells about the changes.

If you wish to enroll in a Medicare Advantage health plan or Medicare prescription drug plan, you have from October 15 until December 7 to make changes to your Medicare coverage for next year. If you decide other Cost plan coverage better meets your needs, you can switch Cost plans anytime the Cost plan is accepting members. You may also change to Original Medicare. For more information see Section 2.2 of this document.

What to do now

1. ASK: Which changes apply to you?

☐ Check the changes to our benefits and costs to see if they affect you.
- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.
- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our **Provider Directory**.

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

☐ Think about whether you are happy with our plan.

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2. COMPARE: Learn about other plan choices.

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at **https://www.medicare.gov** website. Click "Find health & drug plans."
- Review the list in the back of your **Medicare & You** handbook.
- Look in Section 2.2 to learn more about your choices.

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

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

- If you want to **keep** our plan, you don't need to do anything. You will stay in our plan.
- To change to a **Medicare Advantage health plan** or Medicare prescription drug plan, you can switch plans between October 15 and December 7.

4. ENROLL: To change to a Medicare Advantage health plan or Medicare prescription drug plan, join a plan between October 15 and December 7, 2018.

- If you don't **join another plan by December 7, 2018**, you will stay in our plan.
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- Please contact our Member Services number at **1-888-777-5536** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.
- This document is available in Braille or large print if you need it by calling Member Services.

About Kaiser Permanente Medicare Plus Basic w/o D (AB)

- Kaiser Permanente is a Cost plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan). When it says "plan" or "our plan," it means Kaiser Permanente Medicare Plus (Medicare Plus).

Summary of important costs for 2019

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

Cost	2018 (this year)	2019 (next year)
Monthly plan premium	**$5**	**$10**
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	**$6,700**	**$6,700**
Doctor office visits	Primary care visits: **$35** per visit. Specialist visits: **$50** per visit.	Primary care visits: **$35** per visit. Specialist visits: **$50** per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**$1,316** for up to 90 days per benefit period.	**$1,340** for up to 90 days per benefit period.

Annual Notice of Changes for 2019

Table of Contents

Section 1. Changes to benefits and costs for next year

Section 1.1. Changes to the monthly premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$5**	**$10**

Section 1.2. Changes to your maximum out-of-pocket amount

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

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	**$6,700**	**$6,700** Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for these covered services for the rest of the calendar year.

Section 1.3. Changes to the provider network

There are changes to our network of providers for next year. An updated **Provider Directory** is located on our website at **kp.org/directory**. You may also call Member Services for updated provider information or to ask us to mail you a **Provider Directory**. Please review the 2019 **Provider Directory** to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.

- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4. Changes to 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 2019 **Evidence of Coverage**.

Cost	2018 (this year)	2019 (next year)
Emergency Department visits	You pay **$75** per visit.	You pay **$90** per visit.
Inpatient hospital care	You pay **$1,316** for up to 90 days per benefit period.	You pay **$1,340** for up to 90 days per benefit period.
Skilled nursing facility care	Per benefit period, you pay **$164.50** per day for days 21–100.	Per benefit period, you pay **$167.50** per day for days 21–100.

Section 2. Deciding which plan to choose

Section 2.1. If you want to stay in our plan

To stay in our plan you don't need to do anything. If you do not sign up for a different Cost plan or change to Original Medicare by December 31, you will automatically stay enrolled as a member of our plan for 2019.

Section 2.2. If you want to change plans

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

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan.

- Or you can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan, if you don't already have one.

To learn more about Original Medicare and the different types of Medicare plans, read **Medicare & You** 2019, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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

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

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from our plan.
- To add a Medicare prescription drug plan or change to a different drug plan, enroll in the new drug plan. You will continue to receive your medical benefits from our plan.
- To change to Original Medicare with a prescription drug plan, you must enroll in the new drug plan and ask to be disenrolled from our plan. Enrolling in the new drug plan will not automatically disenroll you from our plan. To disenroll from our plan, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
  - Or contact Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.
- To change to Original Medicare without a prescription drug plan, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
  - Or contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

Section 3. Deadline for changing plans

If you want to change to a different type of plan, like a Medicare Advantage plan, or make a change to your prescription drug coverage for next year, you can do it from October 15 until December 7. The change will take effect on January 1, 2019.

If you want to change to a different Cost plan, you can do so anytime the plan is accepting members. The new plan will let you know when the change will take effect.

If you want to disenroll from our plan and have Original Medicare for next year, you can make the change up to December 31. The change will take effect on January 1, 2019.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.1, of the **Evidence of Coverage**.

Section 4. Programs that offer free counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Maryland, the SHIP is called Maryland Department of Aging.
- In Virginia, the SHIP is called Virginia Insurance Counseling and Assistance Program.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIP at:

- Maryland Department of Aging: **410-767-1100** or toll-free **1-800-243-3425** (TTY **711**).
- Virginia Insurance Counseling and Assistance Program: **804-662-9333** or toll-free **1-800-552-3402** (TTY **711**).

Section 5. 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.** Maryland has a program called Maryland Senior Prescription Drug Assistance Program (SPDAP) and Virginia has a program called Virginia HIV SPAP 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 4 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/underinsured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Maryland ADAP or Virginia ADAP depending upon where you live. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **410-767-6535** for Maryland residents or **855-362-0658** for Virginia residents.

Section 6. Questions?

Section 6.1. Getting help from our plan

Questions? We're here to help. Please call Member Services at **1-888-777-5536**. (TTY only, call **711**.) We are available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

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

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

Visit our website

You can also visit our website at **kp.org**. As a reminder, our website has the most up-to-date information about our provider network (**Provider Directory**).

Section 6.2. Getting help from Medicare

To get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227)**
  - You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-**877-486-2048**.
- **Visit the Medicare website**
  - You can visit the Medicare website (**https://www.medicare.gov**). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to **https://www.medicare.gov** and click on "Find health & drug plans.")
- **Read Medicare & You 2019**
  - You can read the **Medicare & You** 2019 handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website

(**https://www.medicare.gov**) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.