Kaiser Permanente Medicare Plus Standard w/Part 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 Standard w/Part 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 the changes in the booklet to our prescription drug coverage to see if they affect you.
- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit **https://go.medicare.gov/drugprices**. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.
- Are your doctors in our network?
- What about the hospitals or other providers you use?

- Look in Section 1.3 for information about our **Provider Directory**.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices.

☐ Check coverage and costs of plans in your area.
- Use the personalized search feature on the Medicare Plan Finder at **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 Standard w/Part 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* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$30**	**$36** *without* Advantage Plus. **$59** *with* Advantage Plus.
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.)	**$6,000**	**$6,700**
Doctor office visits	Primary care visits: **$20** per visit. Specialist visits: **$45** per visit.	Primary care visits: **$10** per visit. Specialist visits: **$45** 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.	**$850** per benefit period.	**$850** per benefit period.
Part D prescription drug coverage (See Section 1.6 for details.)	Preferred cost-sharing during the Initial Coverage Stage (up to a 30-day supply):	
	Tier 4 Deductible: **$300** Drug Tier 1: **$7** Drug Tier 2: **$15** Drug Tier 3: **$42** Drug Tier 4: **$95** Drug Tier 5: **27%** Drug Tier 6: **$0**	Tier 4 Deductible: **$240** Drug Tier 1: **$7** Drug Tier 2: **$15** Drug Tier 3: **$42** Drug Tier 4: **$95** Drug Tier 5: **25%** Drug Tier 6: **$0**

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 without Advantage Plus (You must also continue to pay your Medicare Part B premium.)	**$30**	**$36**
Monthly premium with Advantage Plus This plan premium applies to you only if you are enrolled in optional supplemental benefits, called Advantage Plus. (You must also continue to pay your Medicare Part B premium.)	**Not applicable**	**$59**

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- 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 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 (and other health care services not covered by Medicare as described in Chapter 4 of the **Evidence of Coverage**) 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 and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$6,000**	**$6,700** Once you have paid $6,700 out-of-pocket for covered Part A and Part B services (and certain health care services not covered by Medicare), 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 the pharmacy network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes pharmacies with

preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated **Pharmacy 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 **Pharmacy Directory**. Please review the 2019 **Pharmacy Directory** to see which pharmacies are in our network.

Section 1.5. 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 2019 **Evidence of Coverage**.

Cost	2018 (this year)	2019 (next year)
Emergency Department visits	You pay **$75** per visit.	You pay **$90** per visit.
Eyewear	You pay **85% coinsurance** for contact lenses and **75% coinsurance** for eyeglass lenses and frames.	You have a **$50 allowance** every year. If the eyewear you purchase costs more than $50, you pay the difference.
Fitness benefit (Silver&Fit® Exercise and Healthy Aging Program) With the Silver&Fit program, you can choose membership in a participating fitness facility or the Silver&Fit Home Fitness Program. For more details, see the **Evidence of Coverage** (Chapter 4, Medical Benefits Chart).	**Not covered**	**No charge**
Partial hospitalization	You pay **$20** per day.	You pay **$10** per day.
Primary care office visits	You pay **$20** per visit.	You pay **$10** per visit.
Advantage Plus	**Not applicable**	You have the option to enroll in an optional supplemental benefit package for an additional monthly

Cost	2018 (this year)	2019 (next year)
		premium. See the **Evidence of Coverage** (Chapter 4, Section 2.2) for details.

Section 1.6. Changes to Part D prescription drug coverage

Changes to our Drug List

Our list of covered drugs is called a formulary, or Drug List. A copy of our Drug List is provided electronically at **kp.org**.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.

If you are affected by a change in drug coverage, you can:

- Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug.
  - To learn what you must do to ask for an exception, see Chapter 9 of your **Evidence of Coverage**, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)" or call Member Services.
- Work with your doctor (or other prescriber) to find a different drug that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long-term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days' supply provided in all other cases: 31 days of medication rather than the amount provided in 2018 (90 days of medication). (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.

Because our formulary includes all drugs that can be covered under a Medicare Part D prescription drug plan, it is not likely that we made a formulary exception for you during 2018 to cover a drug that is not on our Drug List. However, in the rare case that we did make a formulary exception during 2018, the exception may continue into 2019 as long as your network provider continues to prescribe the drug for you.

Most of the changes in our Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand-name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may 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. This means if you are taking the brand-name drug that is being replaced by the new generic (or the tier or restriction on the brand-name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand-name drug at a network pharmacy. If you are taking the brand-name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand-name drug at a network pharmacy.

When we make these changes to our Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to our Drug List, see Chapter 5, Section 6, of the **Evidence of Coverage**.)

Changes to prescription drug costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs does not apply to you. We sent you a separate document, 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 haven't received this rider by September 30, 2018, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 6.1 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**.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your nonpreferred brand-name (Tier 4) drugs until you have reached the yearly deductible.	The deductible is **$300**. During this stage, at a preferred network pharmacy, you pay: • **$7** for drugs on **Tier 1** (preferred generic) up to a 30-day supply. • **$15** for drugs on **Tier 2** (nonpreferred generic) up to a 30-day supply. • **$42** for drugs on **Tier 3** (preferred brand-name) up to a 30-day supply. • **27%** coinsurance for drugs on **Tier 5** (specialty). • **$0** for drugs on **Tier 6** (vaccines). • And the full cost of drugs on **Tier 4** (nonpreferred brand-name) until you have reached the yearly deductible.	The deductible is **$240**. During this stage, at a preferred network pharmacy, you pay: • **$7** for drugs on **Tier 1** (preferred generic) up to a 30-day supply. • **$15** for drugs on **Tier 2** (nonpreferred generic) up to a 30-day supply. • **$42** for drugs on **Tier 3** (preferred brand-name) up to a 30-day supply. • **25%** coinsurance for drugs on **Tier 5** (specialty). • **$0** for drugs on **Tier 6** (vaccines). • And the full cost of drugs on **Tier 4** (nonpreferred brand-name) until you have reached the yearly deductible.

Changes to your cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, "Types of out-of-pocket costs you may pay for covered drugs," in your **Evidence of Coverage**.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs	Your cost for a **one-month supply** filled at a network pharmacy: **Tier 1 – Preferred generic drugs:** • Preferred cost-sharing: You pay **$7** per prescription.	Your cost for a **one-month supply** filled at a network pharmacy: **Tier 1 – Preferred generic drugs:** • Preferred cost-sharing: You pay **$7** per prescription.

Stage	2018 (this year)	2019 (next year)
and you pay your share of the cost. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5, of your **Evidence of Coverage**. 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.	• Standard cost-sharing: You pay **$10** per prescription. **Tier 2 – Generic drugs:** • Preferred cost-sharing: You pay **$15** per prescription. • Standard cost-sharing: You pay **$20** per prescription. **Tier 3 – Preferred brand-name drugs:** • Preferred cost-sharing: You pay **$42** per prescription. • Standard cost-sharing: You pay **$47** per prescription. **Tier 4 – Nonpreferred brand-name drugs:** • Preferred cost-sharing: You pay **$95** per prescription. • Standard cost-sharing: You pay **$100** per prescription. **Tier 5 – Specialty-tier drugs:** • You pay **27%** of the total cost. **Tier 6 – Injectable Part D vaccines:** • You pay **$0** per prescription. Once your total drug costs have reached **$3,750**, you will move to the next stage (the Coverage Gap Stage).	• Standard cost-sharing: You pay **$10** per prescription. **Tier 2 – Generic drugs:** • Preferred cost-sharing: You pay **$15** per prescription. • Standard cost-sharing: You pay **$20** per prescription. **Tier 3 – Preferred brand-name drugs:** • Preferred cost-sharing: You pay **$42** per prescription. • Standard cost-sharing: You pay **$47** per prescription. **Tier 4 – Nonpreferred brand-name drugs:** • Preferred cost-sharing: You pay **$95** per prescription. • Standard cost-sharing: You pay **$100** per prescription. **Tier 5 – Specialty-tier drugs:** • You pay **25%** of the total cost. **Tier 6 – Injectable Part D vaccines:** • You pay **$0** per prescription. Once your total drug costs have reached **$3,820**, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages—the Coverage Gap Stage and the 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**.

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 10, 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 and prescription drugs. 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**) and our list of covered drugs (Formulary/Drug List).

Section 6.2. Getting help from Medicare

To get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227)**
  - You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-**877-486-2048**.
- **Visit the Medicare website**
  - You can visit the Medicare website (**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**.