Annual Notice of Changes for 2018

You are currently enrolled as a member of Kaiser Permanente Senior Advantage Medicare Medicaid. Next year, there will be some changes to our plan's costs and benefits. This booklet tells about the changes.

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 2018 Drug List and look in Section 1.6 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 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.
   - If you want to change to a different plan that may better meet your needs, you can switch plans at any time. Your new coverage will begin on the first day of the following month. Look in Section 2.2, page 9, to learn more about your choices.

Additional Resources
   - Please contact our Member Services number at 1-800-805-2739 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 large print if you need it by calling Member Services.
   - Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/ Affordable-Care-Act/Individuals-and-Families for more information.

About Kaiser Permanente Senior Advantage Medicare Medicaid
   - Kaiser Permanente is an HMO SNP plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Kaiser Permanente depends on contract renewal.
   - When this booklet says "we," "us," or "our," it means Kaiser Foundation Health Plan, Inc., Hawaii Region (Health Plan). When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage Medicare Medicaid (Senior Advantage Medicare Medicaid).
Summary of important costs for 2018

The table below compares the 2017 costs and 2018 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.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong></td>
<td>$26.40 if you do not qualify for &quot;Extra Help.&quot;</td>
<td>$24.00 if you do not qualify for &quot;Extra Help.&quot;</td>
</tr>
<tr>
<td>*Your premium may be higher or lower than this amount. See Section 1.1 for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td>Primary care and specialist visits: $0 per visit.</td>
<td>Primary care and specialist visits: $0 per visit.</td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td>$0 per day.</td>
<td>$0 per day.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td>Deductible: $400 Coinsurance during the Initial Coverage Stage, if you do not qualify for &quot;Extra Help&quot;: 25%</td>
<td>Deductible: $405 Coinsurance during the Initial Coverage Stage, if you do not qualify for &quot;Extra Help&quot;: 25%</td>
</tr>
<tr>
<td>(See Section 1.6 for details.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$3,400 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.</td>
<td>$3,400 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.</td>
</tr>
</tbody>
</table>
# Annual Notice of Changes for 2018

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</tbody>
</table>
Section 1. Changes to benefits and costs for next year

Section 1.1. Changes to the monthly premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$26.40</td>
<td>$24.00</td>
</tr>
<tr>
<td>(You must also continue to pay your Medicare Part B premium, unless it is paid for you by Medicaid.)</td>
<td>if you do not qualify for &quot;Extra Help.&quot;</td>
<td>if you do not qualify for &quot;Extra Help.&quot;</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum out-of-pocket amount</td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>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 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.</td>
<td></td>
<td>* Once you have paid $3,400 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.</td>
</tr>
</tbody>
</table>

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 2018

1-800-805-2739, 7 days a week, 8 a.m. to 8 p.m. (TTY 711)
**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.

There are changes to our network of pharmacies for next year. An updated **Pharmacy Directory** is located on our website at [kp.org/directory](http://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 2018 **Pharmacy Directory** to see which pharmacies are in our network.

**Section 1.5. There are no changes to your benefits or amounts you pay for medical services**

Our benefits and what you pay for these covered medical services will be exactly the same in 2018 as they are in 2017.

**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. 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.

1-800-805-2739, 7 days a week, 8 a.m. to 8 p.m. (TTY 711)
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 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 one-time, 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. (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 2017 to cover a drug that is not on our Drug List. However, in the rare case that we did make a formulary exception during 2017, the exception may continue into 2018 as long as your network provider continues to prescribe the drug for you.

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. Because you receive "Extra Help" and haven't received this rider by September 30, 2017, 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 in your Summary of Benefits or at Chapter 6, Sections 6 and 7, in the Evidence of Coverage.)
Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Yearly Deductible Stage</td>
<td>The deductible is $400, if you do not qualify for &quot;Extra Help.&quot;</td>
<td>The deductible is $405, if you do not qualify for &quot;Extra Help.&quot;</td>
</tr>
<tr>
<td></td>
<td>During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible.</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Stage</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2: Initial Coverage Stage</td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing, if you do not qualify for &quot;Extra Help&quot;:</td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing, if you do not qualify for &quot;Extra Help&quot;:</td>
</tr>
<tr>
<td></td>
<td>• You pay 25% of the total cost.</td>
<td>• You pay 25% of the total cost.</td>
</tr>
<tr>
<td></td>
<td>Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).</td>
<td>Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. Most members do not reach either stage. For information

1-800-805-2739, 7 days a week, 8 a.m. to 8 p.m. (TTY 711)
about your costs in these stages, look at your **Summary of Benefits** or 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 plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2018.

**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 2018, follow these steps:

**Step 1: Learn about and compare your choices**

- You can join a different Medicare health plan at any time.
- Or you can change to Original Medicare at any time.

Your new coverage will begin on the first day of the following month. 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, read *Medicare & You 2018*, 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](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. 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 change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from our plan.
- 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.

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.

*1-800-805-2739*, 7 days a week, 8 a.m. to 8 p.m. (TTY 711)
Section 3. Deadline for changing plans

Because you are eligible for both Medicare and Medicaid, 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.

Section 4. Programs that offer free counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Hawaii, the SHIP is called Hawaii SHIP.

Hawaii 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. Hawaii SHIP counselors can help you understand your Medicare plan choices and answer questions about switching plans. You can call Hawaii SHIP at 1-808-586-7299 from Oahu or toll-free at 1-888-875-9229 (TTY users should call 1-866-810-4379). You can learn more about Hawaii SHIP by visiting their website (www.hawaiiship.org).

For questions about your Medicaid benefits, contact the State of Hawaii’s Department of Human Services Med-QUEST Division at 1-800-316-8005, Monday through Friday, 7:45 a.m. to 4:30 p.m. TTY users should call 1-800-603-1201. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

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.** 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, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or 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 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).

- **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 HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered

1-800-805-2739, 7 days a week, 8 a.m. to 8 p.m. (TTY 711)
drugs, or how to enroll in the program, please call the HIV Drug Assistance Program (HDAP) at 808-733-9360.

Section 6. Questions?

Section 6.1. Getting help from our plan

Questions? We're here to help. Please call Member Services at 1-800-805-2739. (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 2018 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 2018. For details, look in the 2018 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 2018
  - You can read the Medicare & You 2018 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.
Section 6.3. Getting help from Medicaid

To get information from Medicaid, you can call the State of Hawaii’s Department of Human Services Med-QUEST Division at 1-800-316-8005, Monday through Friday, 7:45 a.m. to 4:30 p.m. TTY users should call 1-800-603-1201.