MedStar Medicare Choice Care Advantage (HMO SNP) offered by MedStar Family Choice, Inc.

Annual Notice of Changes for 2018

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

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 Sections 1.5 and 1.6 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 healthcare 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 3.2 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** MedStar Medicare Choice Care Advantage, you don't need to do anything. You will stay in MedStar Medicare Choice Care Advantage.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017.**

- If you **don't join by December 7, 2017**, you will stay in MedStar Medicare Choice Care Advantage.
- If you **join by December 7, 2017**, **your new coverage will start on January 1, 2018**.

Additional Resources

- Please contact our Member Services number at **855 222-1041** for additional information. (TTY users should call **855 250-5604**.) Hours are October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. From February 15 through September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.
- This document may be available in an alternative format such as Braille or large print.
- **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 MedStar Medicare Choice Care Advantage (HMO SNP)

- The plan is available to anyone with Medicare who has been diagnosed with Chronic Heart Failure and/or Diabetes. MedStar Medicare Choice Care Advantage (HMO SNP) has a contract with Medicare. Enrollment in MedStar Medicare Choice Care Advantage depends on contact renewal.
- When this booklet says "we," "us," or "our," it means MedStar Family Choice, Inc. When it says "plan" or "our plan," it means MedStar Medicare Choice.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The Formulary, pharmacy network and/or provider network may change at any time.
You will receive notice when necessary.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for MedStar Medicare Choice Care Advantage 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	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$17	$27
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: $5 per visit Specialist visits: $50 per visit	Primary care visits: $5 per visit Specialist visits: $50 per visit

Cost	2017 (this year)	2018 (next year)
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.	You pay: Days 1-5: $350 copay per day, per admission for inpatient hospital care Days 6-90 and beyond: $0 copay per day, per admission for inpatient hospital care Days 1-5: $300 copay per day, per admission for inpatient mental health care Days 6-90 and beyond: $0 copay per day, per admission for inpatient mental health care	You pay: Days 1-5: $350 copay per day, per admission for inpatient hospital care Days 6-90 and beyond: $0 copay per day, per admission for inpatient hospital care Days 1-5: $300 copay per day, per admission for inpatient mental health care Days 6-90 and beyond: $0 copay per day, per admission for inpatient mental health care

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $200 per year for Tiers 3, 4 and 5 Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: $4 copay for a 30-day retail supply • Drug Tier 2: $15 copay for a 30-day retail supply • Drug Tier 3: $47 copay for a 30-day retail supply • Drug Tier 4: $100 copay for a 30-day retail supply • Drug Tier 5: 29% coinsurance for a 30-day retail supply • Drug Tier 6: $10 copay for a 30-day retail supply	Deductible: $405 per year for Tiers 3, 4 and 5 Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: $4 copay for a 30-day retail supply • Drug Tier 2: $15 copay for a 30-day retail supply • Drug Tier 3: $47 copay for a 30-day retail supply • Drug Tier 4: $100 copay for a 30-day retail supply • Drug Tier 5: 25% coinsurance for a 30-day retail supply • Drug Tier 6: $10 copay for a 30-day retail supply

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$17	$27

- 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 enroll in Medicare prescription drug coverage in the future.
- 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 for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your cost for late enrollment penalties (if applicable) and your costs for prescription drugs do 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 your covered Part A and Part B 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 **www.MedStarMedicareChoice.com**. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 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 has changed more than usual for 2018. An updated Pharmacy Directory is located on our website at **www.MedStarMedicareChoice.com**. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **We strongly suggest that you review our current Pharmacy Directory to see if your pharmacy is still 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 *2018 Evidence of Coverage.*

Cost	2017 (this year)	2018 (next year)
Cardiac rehabilitation services	You pay a $0 copay per visit for cardiac rehabilitation services. You pay a $0 copay per visit for intensive cardiac rehabilitation program services.	You pay a $50 copay per visit for cardiac rehabilitation services. You pay a $100 copay per visit for intensive cardiac rehabilitation program services.
Diabetic supplies	You pay a $0 copay for diabetic supplies. Only Bayer and LifeScan® test strips and meters are covered. Other brands of test strips or meters will **NOT** be covered by the plan. Lancets, lancet devices and glucose-control solutions are **NOT** restricted to specific manufacturers and/or brands.	You pay a $0 copay for diabetic supplies. Only LifeScan® test strips and meters are covered. Other brands of test strips or meters will **NOT** be covered by the plan. Lancets, lancet devices and glucose-control solutions are **NOT** restricted to specific manufacturers and/or brands.

Cost	2017 (this year)	2018 (next year)
Emergency care	You pay a $75 copay per visit. The emergency room copay is waived if you are admitted as an inpatient to the hospital within 24 hours for the same condition. The emergency room copay is also waived for observation stays. The emergency room copay is **not** waived if you are admitted to the hospital under the worldwide coverage benefit.	You pay a $80 copay per visit. The emergency room copay is waived if you are admitted as an inpatient to the hospital within 24 hours for the same condition. The emergency room copay is also waived for observation stays. The emergency room copay is **not** waived if you are admitted to the hospital under the worldwide coverage benefit.
Outpatient diagnostic procedures, tests and lab services*	You pay a $0 copay per diagnostic procedure, test or each lab visit for clinical and diagnostic lab services.	You pay 20% of the total cost per diagnostic procedure or test (excluding lab services). You pay a $0 copay for each lab visit for clinical and diagnostic lab services.
Outpatient hospital services – ambulatory surgical center*	You pay a $250 copay for each outpatient surgery and/or services at an ambulatory surgical center.	You pay a $350 copay for each outpatient surgery and/or services at an ambulatory surgical center.
Outpatient hospital services – outpatient surgery*	You pay a $350 copay for each outpatient surgery and/or services at an outpatient hospital facility.	You pay a $400 copay for each outpatient surgery and/or services at an outpatient hospital facility.

Cost	2017 (this year)	2018 (next year)
Partial hospitalization services	You pay a $0 copay per day for partial hospitalization services or intensive outpatient mental health services.	You pay a $55 copay per day for partial hospitalization services or intensive outpatient mental health services.
Pulmonary rehabilitation services	You pay a $0 copay per visit for pulmonary rehabilitation services	You pay a $30 copay per visit for pulmonary rehabilitation services.
Skilled nursing facility (SNF) care*	You pay a $0 copay per day, per admission for days 1-20. You pay a $160 copay per day, per admission for days 21-100.	You pay a $0 copay per day, per admission for days 1-20. You pay a $167.50 copay per day, per admission for days 21-100.
Urgently needed services	You pay a $40 copay per urgent care visit at an urgent care center/clinic.	You pay a $50 copay per urgent care visit at an urgent care center/clinic.

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 in this envelope. The Drug List we included in this envelope 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 at (www.MedStarMedicareChoice.com).

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

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call 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 **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.

In some instances, if you or your provider received approval for a formulary exception for a prescription drug that is not on our current 2017 formulary, the exception approval will continue to be covered in 2018. However, if your original exception approval letter had a specific timeframe for coverage of the prescription drug, that timeframe will still apply (e.g., covered for 3 months); it will not start over in 2018.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We 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 haven't received this insert by September 30, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 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	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Preferred Brand (Tier 3), Non-Preferred Brand (Tier 4) and Specialty (Tier 5) drugs until you have reached the yearly deductible.	The deductible is $200. During this stage, you pay $4 cost-sharing for drugs on Tier 1, $15 cost-sharing for drugs on Tier 2, $10 cost-sharing for drugs on Tier 6, and the full cost of drugs on the Preferred Brand (Tier 3), Non-Preferred Brand (Tier 4), and Specialty (Tier 5) drugs until you have reached the yearly deductible.	The deductible is $405. During this stage, you pay $4 cost-sharing for drugs on Tier 1, $15 cost-sharing for drugs on Tier 2, $10 cost-sharing for drugs on Tier 6, and the full cost of drugs on the Preferred Brand (Tier 3), Non-Preferred Brand (Tier 4), and Specialty (Tier 5) drugs 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	2017 (this year)	2018 (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 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 that provides standard cost-sharing. 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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic Drugs Tier 1:** You pay $4 per prescription. **Generic Drugs Tier 2:** You pay $15 per prescription. **Preferred Brand Drugs Tier 3:** You pay $47 per prescription. **Non-Preferred Brand Drugs Tier 4:** You pay $100 per prescription. **Specialty Drugs Tier 5:** You pay 29% of the total cost. **Select Diabetic Drugs Tier 6:** You pay $10 per prescription. Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic Drugs Tier 1:** You pay $4 per prescription. **Generic Drugs Tier 2:** You pay $15 per prescription. **Preferred Brand Drugs Tier 3:** You pay $47 per prescription. **Non-Preferred Brand Drugs Tier 4:** You pay $100 per prescription. **Specialty Drugs Tier 5:** You pay 25% of the total cost. **Select Diabetic Drugs Tier 6:** You pay $10 per prescription. Once your total drug costs have reached $3,750, 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 Administrative Changes

Cost	2017 (this year)	2018 (next year)
Pharmacy Benefits Manager (PBM) The pharmacy benefits manager (a company that administers, or handles, the drug benefit program) is changing.	The pharmacy benefits manager is Express Scripts, Inc.	The pharmacy benefits manager is CVS Caremark®.
Dental Benefits Administrator – Preventive dental services The dental benefits network provider for routine preventive dental services is changing.	Preventive dental services (such as cleanings, routine dental exams and dental X-rays) are covered by DentaQuest, the plan's dental benefits network provider.	Preventive dental services (such as cleanings, routine dental exams and dental X-rays) are covered by Avesis, the plan's dental benefits network provider.
Vision Care Administrator - Routine vision services The vision benefits network provider for routine vision care services is changing.	Routine vision services are offered through Superior Vision, the plan's routine vision services network provider.	Routine vision services are offered through Avesis, the plan's routine vision services network provider.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in MedStar Medicare Choice Care Advantage

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2018.

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 for 2018 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, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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, MedStar Family Choice 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 MedStar Medicare Choice Care Advantage.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MedStar Medicare Choice Care Advantage.
- 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 7.1 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 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, 2018.

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

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Washington, D.C., the SHIP is called Health Insurance Counseling Project (HICP).

Health Insurance Counseling Project 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. Health Insurance Counseling Project 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 Health Insurance Counseling Project (HICP) at 202-994-6272 (TTY call 202-293-4043). You can learn more about Health Insurance Counseling Project (HICP) by visiting their website (www.law.gwu.edu/Academics/EL/clinics/insurance/Pages/).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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 am and 7 pm, 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/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the District of Columbia AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs or how to enroll in the program, please call 202-671-4900 (TTY users call 711).

SECTION 7 Questions?

Section 7.1 – Getting Help from MedStar Medicare Choice

Questions? We're here to help. Please call Member Services at **855 222-1041** (TTY only, call **855 250-5604**). We are available for phone calls October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. From February 15 through September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 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 MedStar Medicare Choice Care Advantage. 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 envelope.

Visit our Website

You can also visit our website at **www.MedStarMedicareChoice.com**. 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 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

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.

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