Kaiser Permanente Senior Advantage (HMO), an Oregon Public Employees Retirement System (PERS) employer group plan, offered by Kaiser Foundation Health Plan of the Northwest

2025 Annual Notice of Changes for Oregon Public Employees Retirement System (PERS)

You are currently enrolled as a member of Kaiser Permanente Senior Advantage. Next year, there will be some changes to our plan's costs and benefits. This document tells about some of the changes effective January 1, 2025.

The PERS Health Insurance Program (PHIP) Annual Plan Change period is October 1 to November 15, 2024. Plan Changes will be effective January 1, 2025.

Medicare plans not offered by PHIP have an annual enrollment period from October 15 until December 7, 2024, to make changes to your coverage for next year.

2025 changes

We're sending you this **Annual Notice of Changes** to tell you about the changes our plan is making effective January 1, 2025, for all Kaiser Permanente Senior Advantage group members, in accord with the Centers for Medicare & Medicaid Services (CMS) requirements. This notice only describes changes required by our plan (or Medicare for Part D prescription drug plans) and changes made at the request of your group. Please contact PHIP for more information.

What to do now

1. **ASK**: Which changes apply to you?
   - ☐ Check the changes to our benefits and costs to see if they affect you.
     - ♦ Review the changes to medical care costs (doctor, hospital).
     - ♦ Review the changes to our drug coverage, including coverage restrictions and cost sharing.
     - ♦ Think about how much you will spend on premiums, deductibles, and cost sharing.
     - ♦ Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered. Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization for 2025.
   - ☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.
   - ☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.
   - ☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices.

   ☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the **www.medicare.gov/plan-compare** website or review the list in the back of your **Medicare & You** 2025 handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

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

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

   - If you want to keep your Kaiser Permanente Senior Advantage Plan with PHIP, you don't need to do anything. You will stay enrolled in the Kaiser Permanente Senior Advantage Plan.
   - If you decide a different PHIP plan will better meet your needs, you can switch to another PHIP plan between October 1 and November 15, 2024. If you enroll in a new PHIP plan, your coverage will begin on January 1, 2025.
   - To change to a different Medicare plan that may better meet your needs, you can switch plans between October 15 and December 7, 2024. Your coverage will begin on January 1, 2025.

Additional resources

- This Plan, the Kaiser Permanente Senior Advantage Plan, is a PERS Health Insurance Program (PHIP) employer group plan. Disenrolling from the Kaiser Permanente Senior Advantage Plan will disenroll you from PHIP. If you would like to make a change, you may call PHIP to discuss your options at **1-800-768-7377** or local **503-224-7377** (TTY users call **711**) from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. If you leave PHIP you may not be able to rejoin at a later date.
- Please contact our Member Services number at **1-877-221-8221** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.
- This document is available in braille, large print, audio file, or data CD if you need it by calling Member Services.
- Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

About Kaiser Permanente Senior Advantage

- Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
- When this **Annual Notice of Changes** says "we," "us," or "our," it means Kaiser Foundation Health Plan of the Northwest (Health Plan). When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

Annual Notice of Changes for 2025

Table of Contents

Section 1 — Changes to benefits and costs for next year

Section 1.1 – Changes to the monthly premium

Cost	2024 (this year)	2025 (next year)
Monthly plan premium	Premium amounts are changing starting January 1, 2024. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2024.	Premium amounts are changing starting January 1, 2025. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2025.

You must continue to pay your Medicare premiums, and 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 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.
- Your monthly premium may be less if you are receiving "Extra Help" with your prescription drug costs.

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

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services (and other health care services not covered by Medicare as described in the Medical Benefits Chart and Chapter 4 of the **Evidence of Coverage**) for the rest of the year.

There is no change to your maximum out-of-pocket amount for 2025. Your out-of-pocket maximum is **$1,000.**

Section 1.3 – Changes to the provider and pharmacy networks

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

Updated directories are located on our website at **kp.org/directory.** You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 Provider Directory (kp.org/directory) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2025 Pharmacy Directory (kp.org/directory) to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to benefits and costs for medical services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Fitness benefit	You pay **$0** for the Silver&Fit fitness program that includes a basic gym membership, online fitness classes and resources, and home fitness kits (one of which includes an activity tracker).	You pay **$0** for the One Pass™ fitness program that includes access to in-network gyms, online fitness classes and resources, home fitness kits, and an online brain health program. **Beginning January 1st**, you may visit **www.YourOnePass.com** or call **1-877-614-0618** (TTY **711**), Monday through Friday, 6 a.m. to 7 p.m.: • To obtain an access code to provide to your gym or fitness facility. • For information about participating gyms and fitness locations, the program's benefits, or to set up your online account.
Outside service area benefit	You pay **20%** of the Medicare allowable or limiting charges, and any amounts that exceed **$1,000** in Plan Charges per calendar year.	You pay **20%** of the Medicare allowable or limiting charges, and any amounts that exceed **$1,000** in Plan Charges per calendar year.

Cost	2024 (this year)	2025 (next year)
	If you travel outside our service area, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed **$1,000** in covered Plan Charges per calendar year. We will pay up to 80% of the Medicare allowable charge, if the provider accepts assignment. Otherwise, we will pay 80% of the Medicare limiting charge, if the provider does not accept assignment.	If you travel outside our service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed **$1,000** in covered Plan Charges per calendar year. We will pay up to 80% of the Medicare allowable charge, if the provider accepts assignment. Otherwise, we will pay 80% of the Medicare limiting charge, if the provider does not accept assignment.

Section 1.5 – Changes to Part D prescription drug coverage

Changes to our Drug List

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

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

Most of the changes in 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 that will affect you during the plan year. We update our online "Drug List" at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your **Evidence of Coverage** and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our "Drug List" if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may

also decide to keep the brand name drug on our "Drug List," but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your **Evidence of Coverage**. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: **https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients**. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to prescription drug benefits and costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you**. We sent you a separate insert, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2024, please call Member Services and ask for the LIS Rider.

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to your cost-sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: 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**. For information about the costs, 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." Most adult Part D vaccines are covered at no cost to you.	**Tier 1 - Preferred Generic:** You pay up to an $8 copay for each prescription filled up to a 30-day supply from a retail or mail order pharmacy. You pay up to a $16 copay for each prescription filled up to a 60-day supply from a retail or mail order pharmacy. You pay up to a $24 copay for each prescription filled up to a 90-day supply from a retail pharmacy and a $16 copay for up to a 90-day supply from a mail order pharmacy. **Tier 2 - Generic Drugs:** You pay up to a $15 copay for each prescription filled up to a 30-day supply from a retail or mail order pharmacy. You pay up to a $30 copay for each prescription filled up to a 60-day supply from a retail or mail order pharmacy. You pay up to a $45 copay for each prescription filled up to a 90-day supply from a retail pharmacy and a $30 copay for up to a 90-day supply from a mail order pharmacy. **Tier 3 - Preferred brand drugs:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 30-day supply from a retail or mail order pharmacy.	**Tier 1 - Preferred Generic:** You pay up to an $8 copay for each prescription filled up to a 30-day supply from a retail or mail order pharmacy. You pay up to a $16 copay for each prescription filled up to a 60-day supply from a retail or mail order pharmacy. You pay up to a $24 copay for each prescription filled up to a 90-day supply from a retail pharmacy and a $16 copay for up to a 90-day supply from a mail order pharmacy. **Tier 2 - Generic Drugs:** You pay up to a $15 copay for each prescription filled up to a 30-day supply from a retail or mail order pharmacy. You pay up to a $30 copay for each prescription filled up to a 60-day supply from a retail or mail order pharmacy. You pay up to a $45 copay for each prescription filled up to a 90-day supply from a retail pharmacy and a $30 copay for up to a 90-day supply from a mail order pharmacy. **Tier 3 - Preferred brand drugs:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 30-day supply from a retail or mail order pharmacy.

Stage	2024 (this year)	2025 (next year)
	You pay $35 per 30-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 60-day supply from a retail or mail order pharmacy. You pay $70 per 60-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 90-day supply from a retail pharmacy, or 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 90-day supply from a mail order pharmacy. You pay $105 per 90-day supply of each covered insulin product on this tier.	You pay $35 per 30-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 60-day supply from a retail or mail order pharmacy. You pay $70 per 60-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 90-day supply from a retail pharmacy, or 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 90-day supply from a mail order pharmacy. You pay $105 per 90-day supply of each covered insulin product on this tier.
	Tier 4 - Non-preferred drugs: You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 30-day supply from a retail or mail order pharmacy. You pay $35 per 30-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 60-day supply from a retail or mail order pharmacy.	**Tier 4 - Non-preferred drugs:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 30-day supply from a retail or mail order pharmacy. You pay $35 per 30-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 60-day supply from a retail or mail order pharmacy.

Stage	2024 (this year)	2025 (next year)
	You pay $70 per 60-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 90-day supply from a retail pharmacy or 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 90-day supply from a mail order pharmacy. You pay $105 per 90-day supply of each covered insulin product on this tier. **Tier 5 - Specialty drugs:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 30-day supply from a retail pharmacy. You pay $35 per 30-day supply of each covered insulin product on this tier. A long term supply is not available for Tier 5 drugs. **Tier 6 - Vaccines:** You pay $0 copay for injectable vaccines. A long term supply is not available for Tier 6 vaccines. Once you have paid **$5,000** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	You pay $70 per 60-day supply of each covered insulin product on this tier. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 90-day supply from a retail pharmacy or 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 90-day supply from a mail order pharmacy. You pay $105 per 90-day supply of each covered insulin product on this tier. **Tier 5 - Specialty drugs:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 30-day supply from a retail pharmacy. You pay $35 per 30-day supply of each covered insulin product on this tier. A long term supply is not available for Tier 5 drugs. **Tier 6 - Vaccines:** You pay $0 copay for injectable vaccines. A long term supply is not available for Tier 6 vaccines. Once you have paid **$2,000** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage.

Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

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

Section 2 — Administrative changes

Description	2024 (this year)	2025 (next year)
Term of Evidence of Coverage The "Term of the Evidence of Coverage" section in your **Evidence of Coverage** is amended as shown in the 2025 column.	The **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2024, and December 31, 2024, unless amended.	The **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2025, and December 31, 2025, unless amended.
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at **1-877-221-8221** (TTY **711**) or visit **www.medicare.gov**.
Primary Care Provider (PCP) Selection	You may choose one of our available network providers to be your primary care provider.	You must choose one of our available network providers to be your primary care provider. If you do not choose one, we will assign

Description	2024 (this year)	2025 (next year)
		you a PCP or primary care team and notify you accordingly. You can change your assigned PCP at any time.

Section 3 — Deciding which plan to choose

Section 3.1 – 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 offered by PHIP by November 15 or change to a Medicare Plan not offered by PHIP or to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2025.

Section 3.2 – If you want to change plans

The Kaiser Permanente Senior Advantage plan is sponsored by PHIP. Disenrolling from Kaiser Permanente Senior Advantage will disenroll you from PHIP. If you would like to make a change, you may call PHIP to discuss your options at **1-800-768-7377** or local **503-224-7377** (TTY users call **711**) from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. If you leave PHIP you may not be able to rejoin at a later date.

We hope to keep you as a member next year, but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can change to a different PHIP plan between October 1 and November 15, 2024. The change will take effect on January 1, 2025.
- You can join a different Medicare health plan.
- – *OR* – You can change to Original Medicare.

Step 2: Change your coverage

- You can change to a different PERS Health Insurance Program (PHIP) plan offered by another PHIP health plan. You will need to decide between October 1 and November 15, 2024.
- To **change to a different Medicare health plan,** enroll in the new plan. You will automatically be disenrolled from Kaiser Permanente Senior Advantage with PHIP.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Kaiser Permanente Senior Advantage with PHIP.

- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
  - – *OR* – Contact Medicare, at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

DEADLINE FOR CHANGING PLANS

If you want to change to a different PHIP health plan for next year, you can do it from October 1 through November 15, 2024. The change will take effect on January 1, 2025. Please see below if you would like to change to a Medicare plan not offered by the PHIP or to Original Medicare.

ARE THERE OTHER TIMES OF THE YEAR TO MAKE A CHANGE?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Section 4 — Programs that offer free counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA) and in Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA).

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 Oregon SHIBA at **1-800-722-4134** (TTY **1-800-735-2900**). You can call Washington SHIBA at **1-800-562-6900** (TTY **1-360-586-0241**). You can learn more about Oregon SHIBA by visiting their website (**https://shiba.oregon.gov**). You can learn more about Washington SHIBA by visiting their website (**https://www.insurance.wa.gov/shiba**).

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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. 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 8 a.m. and 7 p.m., Monday through Friday, for a representative. Automated messages are available 24 hours a day. TTY users should call **1-800-325-0778**; or
- Your state Medicaid office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through **CAREAssist** for Oregon residents and the **Early Intervention Program** for Washington residents. For information on eligibility criteria, covered drugs, how to enroll in the program, or if you are currently enrolled, how to continue receiving assistance, call **CAREAssist** at **1-800-805-2313** for Oregon residents and the **Early Intervention Program** at **1-877-376-9316** for Washington residents. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at **1-877-221-8221** (TTY **711**) or visit **www.medicare.gov**.

Section 6 — Questions?

Section 6.1 – Getting help from our plan

Questions? We're here to help. Please call Member Services at **1-877-221-8221**. (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 2025 Evidence of Coverage (it has details about next year's benefits and costs)

This **Annual Notice of Changes** gives you a summary of changes in your benefits and costs for 2025 that our plan is making. Please keep in mind that groups can make changes to your group plan at any time. For details, look in the 2025 **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 notice that tells you where you can view your **Evidence of Coverage** online and how to order a print copy is

included in this envelope/booklet. A copy of the **Evidence of Coverage** is located on our website at **https://my.kp.org/pers**.

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**). **Note:** 2025 plan documents will be posted on our website early in October 2024.

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**
  - Visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to **www.medicare.gov/plan-compare**.
- **Read Medicare & You 2025**
  - Read the **Medicare & You** 2025 handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (**https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf**) or by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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How to contact PERS Health Insurance Program (PHIP) Customer Service

For assistance with plan premiums, changes, updating your name, address, and phone numbers, please call or write to PHIP Customer Service.

METHOD	PERS Health Insurance Program (PHIP) Customer Service – Contact Information
CALL	**1-800-768-7377** Calls to this number are free. Customer Service is available from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. This number is available 24 hours a day, seven days a week.
FAX	**503-765-3452** or **1-888-393-2943**
WRITE	**PERS Health Insurance Program (PHIP)** P.O. Box 40187 Portland, OR 97240-0187 persinfo@pershealth.com
WEBSITE	**pershealth.com**

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services – Contact Information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**my.kp.org/pers**

Notice of Nondiscrimination

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-813-2000** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at: Member Relations Department, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY **711**), Fax: **1-855-347-7239**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **1-800-537-7697 (TDD)**. Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For Washington Members

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at **1-800-562-6900**, or **360-586-0241 (TDD)**. Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

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Form Approved
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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-877-221-8221** (TTY **711**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-877-221-8221** (TTY **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-877-221-8221** (TTY **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-877-221-8221** (TTY **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-877-221-8221** (TTY **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-877-221-8221** (TTY **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-877-221-8221** (TTY **711**). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-877-221-8221** (TTY **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-877-221-8221** (TTY **711**). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-877-221-8221** (TTY **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY **711**) **1-877-221-8221**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-877-221-8221** (TTY **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-877-221-8221** (TTY **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-877-221-8221** (TTY **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-877-221-8221** (TTY **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-877-221-8221** (TTY **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-877-221-8221** (TTY **711**). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Plan Information

As member of this plan, we may occasionally contact you to inform you of other Kaiser Permanente plans or products that may be available to you. If you wish to opt-out of these types of calls, please contact Member Services at the phone number on the back of your member ID card.

Provider Directories

If you need help finding a network provider or pharmacy, please visit **kp.org/directory** to search our online directory (Note: the 2025 directories are available online starting 10/01/2024 in accord with Medicare requirements).

To get a **Provider Directory**, or **Pharmacy Directory** (if applicable), mailed to you, you can call Kaiser Permanente at **1-877-221-8221 (TTY 711)** 7 days a week, 8 a.m. to 8 p.m.

Medicare Part D Prescription Drug Formulary

Our formulary lists the Medicare Part D drugs we cover. The formulary may change at any time. You'll be notified when necessary. If you have a question about covered drugs, see our online formulary at **kp.org/seniorrx** (Note: the 2025 formulary is available online starting 10/01/2024 in accord with Medicare requirements).

To get a formulary mailed to you, you can call Kaiser Permanente at **1-877-221-8221 (**TTY **711)**, 7 days a week, 8 a.m. to 8 p.m.

Evidence of Coverage (EOC)

Your **EOC** explains how to get medical care and prescription drugs covered through your plan. It explains your rights and responsibilities, what's covered, and what you pay as a Kaiser Permanente member. If you have a question about your coverage, visit **my.kp.org/pers** to view your **EOC** online (Note: the 2025 **EOC** for Northwest is available online starting 10/15/2024 in accord with Medicare requirements).

To get an **EOC** mailed to you, you can call Kaiser Permanente at **1-877-221-8221 (**TTY **711)**, 7 days a week, 8 a.m. to 8 p.m.

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