Dear Member:

Thank you for your continued membership in **Kaiser Permanente Senior Advantage** (HMO).

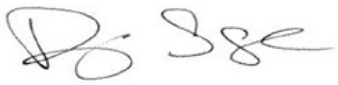
We are providing important information about your Medicare health care and prescription drug coverage effective January 1, 2022. Included are the following documents with important information for you.

1. Please start by reading the **Annual Notice of Changes and Evidence of Coverage Amendment for 2022**. It gives you a summary of changes we are making to your benefits and costs effective January 1, 2022. This notice describes changes that our plan is making (or as required by Medicare for Part D plans) and changes made at the request of your group.
    - Please review this notice within a few days of receiving it to see how the changes might affect you. It also amends your current **Evidence of Coverage**, effective January 1, 2022. We will send you the **Evidence of Coverage** for your group's 2022 contract period shortly after your group renews its contract in 2022. Please be aware that your group can make changes upon renewal or at other times during its contract period. If you have questions about the benefits your group will offer during its 2022 contract period, please contact the PERS Health Insurance Program (PHIP).
    - If you decide to stay with our plan, you do not have to fill out any paperwork unless you are instructed otherwise by your group. You will automatically stay enrolled as a member of our plan.
    - If you decide to leave our plan, you should check with PHIP before you switch to a different plan. Your group determines eligibility for enrollment under its group plan, including the available plans, if any, and the times when you can switch to a different plan offered by your group. Please contact PHIP for details.
2. A notice called **Additional plan information** explains how to get information about provider locations or our formulary, request a print copy of our **Formulary/Drug List** or **Provider Directory**, or view them online.

If you have questions, we're here to help. Please call Member Services toll free at **1-877-221-8221** (TTY users call **711**). Hours are seven days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers. You can also visit our website at **kp.org**.

We value your membership and hope to continue to serve you next year.

Sincerely,



Brian E. Sage
Director, Medicare

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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

2022 Annual Notice of Changes and Evidence of Coverage Amendment 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 booklet tells about some of the changes effective January 1, 2022. It also amends your current **Evidence of Coverage**.

The PERS Health Insurance Program (PHIP) Annual Plan Change period is October 1 to November 15, 2021. Plan Changes will be effective January 1, 2022.

Medicare plans not offered by PHIP have an annual enrollment period from October 15 until December 7, 2021, to make changes to your coverage for next year.

2022 changes

We're sending you this **Annual Notice of Changes and Evidence of Coverage Amendment** to tell you about the changes our plan is making effective January 1, 2022, for all Kaiser Permanente Senior Advantage group members, in accord with the Centers for Medicare & Medicaid Services (CMS) requirements. This notice 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.
     - ♦ 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?
- Look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit **go.medicare.gov/drugprices**, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, 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 **www.medicare.gov/plan-compare** website.
- 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 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, 2021. If you enroll in a new PHIP plan, your coverage will begin on January 1, 2022.
   - The information below is for general Medicare enrollment; contact the PERS Health Insurance Program for details regarding their enrollment and Plan Change guidelines.
   - To change to a different Medicare plan that may better meet your needs, you can switch plans between October 15 and December 7, 2021. Your coverage will begin on January 1, 2022.
4. **ENROLL:** To change to a different PHIP Plan during the PHIP Plan Change period of October 1 through November 15, 2021, contact the PHIP or go online at **pershealth.com** for more information. The following information is for general Medicare enrollment; contact the PHIP for details regarding their enrollment and Plan Change guidelines.
   - To change to a plan outside of PHIP, join a plan between October 15 and December 7, 2021.
   - If you don't join another plan by December 7, 2021, you will stay in the Kaiser Permanente Senior Advantage Plan with PHIP.
   - If you join another plan by December 7, 2021, your new coverage will start on January 1, 2022.

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 document is available in large print 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 and Evidence of Coverage Amendment** 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 and Amendment

Table of Contents

Section 1 — Changes to benefits and costs for next year

Section 1.1 – Changes to the monthly premium

Cost	2021 (this year)	2022 (next year)
Monthly plan premium	Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2021.	Premium amounts are changing starting January 1, 2022. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2022.

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

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 the Medical Benefits Chart and Chapter 4 of the **Evidence of Coverage**) for the rest of the year.

There is no change to your out-of-pocket maximum for 2022. Your out-of-pocket maximum is **$1,000**.

Section 1.3 – Changes to the provider network

There are changes to our network of providers for next year. Early in October 2021, we will post our 2022 **Provider Directory** 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 our 2022 **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, we must 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 to manage 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. Early in October 2021, we will post our 2022 **Pharmacy Directory** on our website at **kp.org/directory**. You may also call Member Services for updated pharmacy information or to ask us to mail you a **Pharmacy Directory**. Please review our 2022 **Pharmacy Directory** to see which pharmacies are in our network.

Section 1.5 – Changes to benefits and costs for medical services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," and the Medical Benefits Chart located at the front of your **Evidence of Coverage**.

Cost	2021 (this year)	2022 (next year)
Eyewear allowance per two-calendar-year period	Balance after **$100 allowance** once within a two-calendar-year period.	Balance after **$200 allowance** once within a two-calendar-year period.

Cost	2021 (this year)	2022 (next year)
Fitness benefit (the Silver&Fit® Healthy Aging and Exercise Program) The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein.	You can choose one of the following: • A standard gym membership. • Two home fitness kits from a variety of kits.	You receive the following: • A standard gym membership. • A home fitness kit to exercise at home (you can also choose a kit that includes an activity tracker).
Hearing aid allowance per calendar year	Balance after **$200** allowance is applied per hearing aid per ear each year.	Balance after **$400** allowance is applied per hearing aid per ear each year.
Hearing services • Diagnostic hearing and balance evaluations. • Routine hearing exams.	**$15** per visit.	**$0**
Home medical care not covered by Medicare (acute care at home) **This benefit is unavailable to members in Lane County.** Medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status, to provide you with an alternative to receiving acute care in a hospital, including the following services and items **in accord with your home treatment plan**: • Communication devices to allow for member contact with our network provider's command center 24 hours a day, 7 days a week.	Not covered.	You pay **$0** when prescribed as part of your home treatment plan, otherwise not covered (see the **Evidence of Coverage** for details).

Cost	2021 (this year)	2022 (next year)
• Certain equipment to ensure appropriate member monitoring in the home. • Certain safety items. • Meals while receiving acute care in the home.		
Certain Medicare-covered services and items prescribed as part of your home treatment plan, including, but not limited to, acute care, emergency department visits, ambulance, home visits by certain healthcare professionals, imaging and tests such as X-rays and EKGs, outpatient hospital services, durable medical equipment (DME), and medical supplies.	You pay the applicable cost-sharing described in your 2021 **Evidence of Coverage**, Chapter 4, Medical Benefits Chart.	You pay **$0** when prescribed as part of your home treatment plan, otherwise you pay the applicable cost share (see the **Evidence of Coverage** for details).

Section 1.6 – Changes to Part D prescription drug coverage

Changes to our Drug List

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

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, and complaints)" or call Member Services.
- Work with your doctor (or other prescriber) to find a different drug that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (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.

Note: Certain drugs have been removed from our 2022 Drug List. If your drug has been removed from our Drug List, you can discuss with your physician if there are other drugs on our Drug List that will work for you. If your physician determines that the other drugs will not work for you, you or your physician can request that we make a formulary exception. If we approve your request for brand-name drugs, you will pay the cost-sharing applicable to Tier 4 drugs (nonpreferred brand-name), or for generic drugs, you will pay the cost-sharing applicable to Tier 2 drugs (generic). In addition, if we approved a formulary exception for you during 2021, you or your physician will need to ask us for a formulary exception for 2022.

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.

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

Changes to prescription drug costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs does not apply to you. We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and if you haven't received this rider by September 30, 2021, please call Member Services and ask for the "LIS Rider."

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 stage—the Catastrophic Coverage Stage.) To get information about your costs in these stages, look at Chapter 6 in the **Evidence of Coverage**.

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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

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	2021 (this year)	2022 (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. 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.	**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	**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

Stage	2021 (this year)	2022 (next year)
	each prescription filled, up to a 30-day supply from a retail or mail order pharmacy. 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 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. **Tier 4 - Non-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. 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 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.	each prescription filled, up to a 30-day supply from a retail or mail order pharmacy. 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 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. **Tier 4 - Non-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. 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 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.

Stage	2021 (this year)	2022 (next year)
	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. 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 **$6,550** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	**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. 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 **$7,050** 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 other drug coverage stage—the Catastrophic Coverage Stage—is for people with high drug costs. Most members do not reach the Catastrophic Coverage Stage. For information about your costs in this stage, look at Chapter 6, Section 7, in your **Evidence of Coverage**.

Section 2 — Administrative changes

Description	2021 (this year)	2022 (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 2022 column.	Your group renews its **Agreement** with us on January 1st. The term of your current **Evidence of Coverage** is revised to be in effect for the months in which you are enrolled in Senior Advantage between January 1, 2021, and December 31, 2021, unless amended.	Your group renews its **Agreement** with us on January 1st. The term of your current **Evidence of Coverage** is revised to be in effect for the months in which you are enrolled in Senior Advantage between January 1, 2022, and December 31, 2022, unless amended.

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 2022.

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 for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can change to a different PHIP plan between October 1, 2021 and November 15, 2021. The change will take effect on January 1, 2022.
- You can join a different Medicare health plan timely.
- – *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.
- 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 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**.

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. The change will take effect on January 1, 2022. 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. 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 may be 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**.

Section 4 — Programs that offer free counseling about Medicare

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

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call 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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
  - The Social Security office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
  - Your state Medicaid office (applications).

- **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 **CAREAssist** for Oregon residents and the **Early Intervention Program** for Washington residents. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call CAREAssist at **1-800-805-2313** for Oregon residents and the Early Intervention Program at **1-877-376-9316** for Washington residents.

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 2022 Evidence of Coverage (it has details about benefits and costs)

This **Annual Notice of Changes and Evidence of Coverage Amendment** gives you a summary of some changes in your benefits and costs for 2022 that our plan is making and it amends your current **Evidence of Coverage**. We will send you the **Evidence of Coverage** for your group's 2022 contract period shortly after your group renews its contract in 2022. A copy of the **Evidence of Coverage** is located on our website at **https://my.kp.org/pers**. Please keep in mind that groups can make changes to your group plan at any time.

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: 2022 plan documents will be posted on our website early in October 2021.

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 (**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 **www.medicare.gov/plan-compare**).

- **Read Medicare & You 2022**
  - You can read the **Medicare & You** 2022 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 (**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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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	Member Services Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**my.kp.org/pers**

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-877-221-8221** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 500 NE Multnomah St., Suite 100, Portland OR 97232 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. 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, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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Multi-language Interpreter Services

English

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-221-8221** (TTY: **711** .

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-221-8221** (TTY: **711** .

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-221-8221**（TTY：**711**）。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-221-8221** (TTY: **711** .

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-221-8221** (TTY: **711** .

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-877-221-8221 (TTY: **711** 번으로 전화해 주십시오.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-221-8221** (телетайп: **711** .

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-221-8221**（TTY:**711**）まで、お電話にてご連絡ください。

Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-877-221-8221

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-877-221-8221** (TTY: **711**)។

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Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-221-8221** (TTY:**711** .

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-877-221-8221** (TTY: **711**) تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-221-8221** (رقم هاتف الصم والبكم: -**711**).

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-877-221-8221** (መስማት ተሳናቸው : **711**).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-221-8221** (TTY: **711**).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-221-8221** (ATS : **711**).

Cushite-Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-221-8221** (TTY: **711** .

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-877-221-8221** (TTY: **711** .

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-877-221-8221** (телетайп: **711** .

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-877-221-8221** (TTY: **711** .

Plan information

Provider directories

If you need help finding a network provider or pharmacy, please visit **kp.org/directory** to search our online directory (Note: the 2022 directories are available online starting 10/01/2021 in accord with Medicare requirements).

To get a Provider Directory, or Dental 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 (Note: the 2022 formulary is available online starting 10/01/2021 in accord with Medicare requirements) at **kp.org/seniorrx.**

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.

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