Kaiser Permanente Medicare Advantage Standard DC (HMO-POS) Offered by Kaiser Foundation Health Plan of the Mid Atlantic States, Inc. (Standard DC)

Annual Notice of Changes for 2025

You are currently enrolled as a member of Kaiser Permanente Medicare Advantage Standard DC. Next year, there will be changes to our plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium***.

This document tells about the changes to your plan. To get more information about costs, benefits, or rules, please review the *Evidence of Coverage,* which is located on our website at kp.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

- **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.

- 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 our 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 our plan's website.

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

- If you don't join another plan by December 7, 2024, you will stay in Kaiser Permanente Medicare Advantage Standard DC.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1**, **2025**. This will end your enrollment with Kaiser Permanente Medicare Advantage Standard DC.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member Services number at 1-888-777-5536 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week. This 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 Medicare Advantage Standard DC

- Kaiser Permanente is an HMO-POS plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
- When this document says "we," "us," or "our," it means Kaiser Foundation Health Plan of the Mid-Atlantic States Inc. (Health Plan). When it says "plan" or "our plan," it means Kaiser Permanente Medicare Advantage Standard DC.

Annual Notice of Changes for 2025

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Kaiser Permanente Medicare Advantage Standard DC in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$30**	**$30**
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.)	**$6,900**	**$6,900**
Doctor office visits	Primary care visits: **$5** per visit. Specialist visits: **$40** per visit.	Primary care visits: **$5** per visit. Specialist visits: **$35** per visit.
Inpatient hospital stays	Per admission, **$295** per day for days 1–5 ($0 for the rest of your stay).	Per admission, **$245** per day for days 1–5 ($0 for the rest of your stay).
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: **$0** Preferred cost-sharing during the Initial Coverage Stage (up to a 30-day supply): Drug Tier 1: **$0** Drug Tier 2: **$12**	Deductible: **$0** Preferred cost-sharing during the Initial Coverage Stage (up to a 30-day supply): Drug Tier 1: **$0** Drug Tier 2: **$12**

Cost	2024 (this year)	2025 (next year)
	Drug Tier 3: **$45** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 4: **$100** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 5: **33%** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 6: **$0** Catastrophic Coverage: During this payment stage, our plan pays the full cost for your covered Part D drugs. You pay nothing.	Drug Tier 3: **$45** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 4: **$100** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 5: **33%** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 6: **$0** Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs.

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 premium without optional supplemental benefits (You must also continue to pay your Medicare Part B premium.)	**$30**	**$30**
Monthly premium with optional supplemental benefits One of these plan premiums applies to you only if you are enrolled in one or both of our optional supplemental benefits packages. (You must also continue to pay your Medicare Part B premium.)		
Advantage Plus Option 1	**$48**	**$48**
Advantage Plus Option 2	**$53**	**$53**
Both Advantage Plus Options	**$71**	**$71**

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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 Chapter 4 of the *Evidence of Coverage*) for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$6,900**	**$6,900** Once you have paid $6,900 out-of-pocket for covered Part A and Part B services (and certain health care services not covered by Medicare), you will pay nothing for these covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

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)
Ambulance Services	You pay **$275** per one-way trip.	You pay **$225** per one-way trip.
Cardiac Rehabilitation Services	You pay **$30** per cardiac rehabilitation visit or **$40** per intensive cardiac rehabilitation visit.	You pay **$35** per cardiac rehabilitation visit or **$35** per intensive cardiac rehabilitation visit.
Dental services We cover certain preventive and comprehensive dental care: Comprehensive dental care Your annual benefit limit is increased if you are enrolled in optional supplemental benefits called Advantage Plus Option 1 or Advantage Plus Option 2. Refer to the *Evidence of Coverage* for details about what dental services are covered.	You pay **50% coinsurance** for comprehensive dental care until the plan has paid **$1,000 (annual benefit limit)**. When you reach the $1,000 annual benefit limit for comprehensive dental care, you pay 100% for the rest of the year.	You pay **50% coinsurance** for comprehensive dental care until the plan has paid **$2,500 (annual benefit limit)**. When you reach the $2,500 annual benefit limit for comprehensive dental care, you pay 100% for the rest of the year.
Dental - Pre-transplant Dental services necessary to ensure the oral cavity is clear of infection prior to being placed on the transplant wait list for allogeneic stem cell/bone marrow, heart, kidney, liver, lung, pancreas, and multiple-organ transplants.	You pay **$40** per visit.	You pay **$35** per visit.
Emergency Department	You pay **$100** per visit.	You pay **$110** per visit.

Cost	2024 (this year)	2025 (next year)
Eye Exams	You pay **$0** for diabetic retinopathy, **$5** per visit with an optometrist, or **$40** per visit with an ophthalmologist.	You pay **$0** for diabetic retinopathy, **$5** per visit with an optometrist, or **$35** per visit with an ophthalmologist.
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 and home fitness kits. **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.
Hearing Exams	You pay **$40** per visit.	You pay **$35** per visit.
Home medical care not covered by Medicare (advanced care at home) 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	**Not covered**.	You pay **$0** when prescribed as part of your home treatment plan, otherwise not covered (see the *Evidence of Coverage*, Chapter 4, Medical Benefits Chart, for details).

Cost	2024 (this year)	2025 (next year)
receiving acute care in a hospital, including the following services and items **in accord with your home treatment plan**: • Telemonitoring devices to monitor the member's condition.		
• Certain Medicare-covered services and items prescribed as part of your home treatment plan, including, but not limited to, acute care, emergency department visits, home visits by certain healthcare professionals, imaging and tests such as X-rays and EKGs, and medical supplies.	You pay the applicable cost-sharing described in your 2024 *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 2025 *Evidence of Coverage*, Chapter 4, Medical Benefits Chart, for details).
Inpatient Acute Care	You pay **$295** per day for days 1-5 ($0 for the rest of your stay).	You pay **$245** per day for days 1-5 ($0 for the rest of your stay).
Inpatient Mental Health Care	You pay **$295** per day for days 1-5 ($0 for the rest of your stay).	You pay **$245** per day for days 1-5 ($0 for the rest of your stay).
Occupational Therapy Services	You pay **$40** per visit.	You pay **$35** per visit.
Opioid Treatment Program Services	You pay **$40** per visit.	You pay **$35** per visit.
Outpatient Hospital Services	You pay **$0** or **$250** per visit, depending on the service.	You pay **$0** or **$130** per visit, depending on the service.

Cost	2024 (this year)	2025 (next year)
Observation Services	You pay **$0** when transferred for observation from an Emergency Department or following outpatient surgery or **$250** per stay, when admitted directly to the hospital for observation as an outpatient.	You pay **$0** when transferred for observation from an Emergency Department or following outpatient surgery or **$130** per stay, when admitted directly to the hospital for observation as an outpatient.
Outpatient Surgery in an Ambulatory Surgical Center – Medicare covered	You pay **$250** per visit.	You pay **$130** per visit.
Over-the-Counter (OTC) We cover OTC items listed in our OTC catalog for free home delivery.	You may order OTC items up to the **$60** quarterly benefit limit.	You may order OTC items up to the **$80** quarterly benefit limit.
Physical and Speech Therapy	You pay **$40** per visit.	You pay **$35** per visit.
Podiatry Services	You pay **$40** per visit.	You pay **$35** per visit.
Pulmonary Rehabilitation Services	You pay **$15** per visit.	You pay **$25** per visit.
Radiation Therapy	You pay **$40** per visit.	You pay **$35** per visit.
Specialist Office Visits	You pay **$40** per visit.	You pay **$35** per visit.
Supervised Exercise Therapy (SET)	You pay **$25** per visit.	You pay **$20** per visit.
Urgent Care Office Visits	You pay **$40** per visit.	You pay **$35** per visit.
Advantage Plus Option 1 (optional supplemental benefits) This change only applies to members who have signed up for		

Cost	2024 (this year)	2025 (next year)
optional supplemental benefits, called Advantage Plus Option 1, for an additional monthly premium.		
• Eyewear.	You receive an additional **$175** eyewear allowance added to your standard allowance every 24 months, which results in a combined allowance of $425. If the eyewear you purchase costs more than $425, you pay the difference.	You receive an additional **$275** eyewear allowance added to your standard allowance every 24 months, which results in a combined allowance of $525. If the eyewear you purchase costs more than $525, you pay the difference.

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 our 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 the Drug List are new for the beginning of each year. However, 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.** 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 our "Drug List." Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply is: Tier 1 – Preferred Generic drugs: • Preferred cost-sharing: You pay **$0** per prescription. • Standard cost-sharing: You pay **$10** per prescription. Tier 2 – Generic drugs: • Preferred cost-sharing: You pay **$12** per prescription. • Standard cost-sharing: You pay **$20** per prescription. Tier 3 – Preferred Brand drugs: • Preferred cost-sharing: You pay **$45** per prescription.	Your cost for a one-month supply is: Tier 1 – Preferred Generic drugs: • Preferred cost-sharing: You pay **$0** per prescription. • Standard cost-sharing: You pay **$10** per prescription. Tier 2 – Generic drugs: • Preferred cost-sharing: You pay **$12** per prescription. • Standard cost-sharing: You pay **$20** per prescription. Tier 3 – Preferred Brand drugs: • Preferred cost-sharing: You pay **$45** per prescription.

Stage	2024 (this year)	2025 (next year)
	• Standard cost-sharing: You pay **$47** per prescription. Tier 4 – Non-Preferred drugs: • Preferred cost-sharing: You pay **$100** per prescription. • Standard cost-sharing: You pay **$100** per prescription. Tier 5 – Specialty Tier drugs: • You pay **33%** of the total cost. Tier 6 – Injectable Part D vaccines: • You pay **$0** per prescription. Once your total drug costs have reached **$5,030**, you will move to the next stage (the Coverage Gap Stage).	• Standard cost-sharing: You pay **$47** per prescription. Tier 4 – Non-Preferred drugs: • Preferred cost-sharing: You pay **$100** per prescription. • Standard cost-sharing: You pay **$100** per prescription. Tier 5 – Specialty Tier drugs: • You pay **33%** of the total cost. Tier 6 – Injectable Part D vaccines: • You pay **$0** per prescription. 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.

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)
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 1-888-777-5536 or visit www.medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Kaiser Permanente Medicare Advantage Standard DC

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 be enrolled in our Kaiser Permanente Medicare Advantage Standard DC.

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 plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a

Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Kaiser Permanente offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Kaiser Permanente Medicare Advantage Standard DC.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Kaiser Permanente Medicare Advantage Standard DC.
- 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.

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, 2025.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 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 the District of Columbia, the SHIP is called DC Department of Aging and Community Living.

It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. The DC Department of Aging and Community Living 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 the DC Department of Aging and Community Living at **1-202-727-8370** (TTY **711**).

SECTION 6 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 the District of Columbia ADAP. 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 the District of Columbia ADAP at 1-202-671-4815. 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 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 1-888-777-5536 or visit www.medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Our Plan

Questions? We're here to help. Please call Member Services at 1-888-777-5536. (TTY only, call 711.) We are available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your *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*. 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 copy of the *Evidence of Coverage* is located on our website at kp.org/eocmasma. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at kp.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/Drug List)*.

Section 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

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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Kaiser Permanente Medicare Advantage Member Services

Method	Member Services – contact information
CALL	**1-888-777-5536** 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 Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
WEBSITE	kp.org

OMB Approval 0938-1051 (Expires: August 31, 2026)

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 **1-888-777-5536** (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 2101 East Jefferson Street, Rockville, MD 20852 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**, **1-800-537-7697** (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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June 2023

Form Approved
OMB# 0938-1421

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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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**) **1-888-777-5536**. 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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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、**1-888-777-5536** (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 October 15, 2024 in accord with Medicare requirements).

To get a Provider Directory, Dental Provider Directory, or Pharmacy Directory (if applicable), mailed to you, you can call Kaiser Permanente at **1-888-777-5536** (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 October 15, 2024 in accord with Medicare requirements).

To get a formulary mailed to you, you can call Kaiser Permanente at **1-888-777-5536** (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 **kp.org/eocmas** to view your **EOC** online (Note: the 2025 **EOC** for the Mid-Atlantic states is available online starting October 15, 2024 in accord with Medicare requirements).

To get an **EOC** mailed to you, you can call Kaiser Permanente at **1-888-777-5536** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

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