

## Kaiser Permanente Senior Advantage Santa Clara County Basic Plan (HMO) offered by Kaiser Foundation Health Plan, Inc., Northern California Region (Santa Clara County Basic Plan)

### Annual Notice of Change for 2026

You're enrolled as a member of Kaiser Permanente Senior Advantage Santa Clara County Basic plan.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Kaiser Permanente Senior Advantage Santa Clara County Basic plan.
- To change to a **different plan**, visit [www.Medicare.gov](http://www.Medicare.gov) or review the list in the back of your Medicare & You 2026 handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [kp.org](http://kp.org) or call Member Services at 1-800-443-0815 (TTY users call 711) to get a copy by mail.

#### More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-800-443-0815 (TTY users call 711) for more information. 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.

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**About Kaiser Permanente Senior Advantage Santa Clara County Basic plan**

- Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means Kaiser Foundation Health Plan, Inc., Northern California Region (Health Plan). When it says “plan” or “our plan,” it means Kaiser Permanente Senior Advantage Santa Clara County Basic Plan (Senior Advantage).
- **If you do nothing by December 7, 2025, you’ll automatically be enrolled in Kaiser Permanente Senior Advantage Santa Clara County Basic plan.** Starting January 1, 2026, you’ll get your medical and drug coverage through Kaiser Permanente Senior Advantage Santa Clara County Basic plan. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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## Summary of Important Costs for 2026

|                                                                                                                                                                                                                                                                                               | 2025<br>(this year)                                                        | 2026<br>(next year)                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>* Your premium can be higher or lower than this amount. Go to Section 1.1 for details.                                                                                                                                                                        | \$0                                                                        | \$15                                                                       |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)                                                                                                                              | \$6,000                                                                    | \$6,000                                                                    |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                                             | \$5 per visit.                                                             | \$5 per visit.                                                             |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                                               | \$15 per visit.                                                            | \$20 per visit.                                                            |
| <b>Inpatient hospital stays</b><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're | Per admission, \$245 per day for days 1–5 (\$0 for the rest of your stay). | Per admission, \$320 per day for days 1–5 (\$0 for the rest of your stay). |

|                                                                                                                                                  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| discharged is your last inpatient day.                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Part D drug coverage deductible</b><br><br>(Go to Section 1.7 for details.)                                                                   | \$0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | <p>Cost-sharing during the Initial Coverage Stage:</p> <p>Drug Tier 1: \$3<br/>You pay \$0 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 2: \$12<br/>You pay \$0 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 3: \$47<br/>You pay \$25 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: \$100<br/>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5: 33%<br/>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 6: \$0</p> <p>Catastrophic Coverage Stage:</p> | <p><b>Cost-sharing during the Initial Coverage Stage:</b></p> <p><b>Drug Tier 1: \$0</b></p> <p><b>Drug Tier 2: \$0</b></p> <p><b>Drug Tier 3: \$40</b><br/><b>You pay \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 4: \$90</b><br/><b>You pay \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 5: 33%</b><br/><b>You pay \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 6: \$0</b></p> <p><b>Catastrophic Coverage Stage:</b></p> |

|  | 2025<br>(this year)                                                             | 2026<br>(next year)                                                                      |
|--|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
|  | During this payment stage,<br>you pay nothing for your<br>covered Part D drugs. | <b>During this payment stage,<br/>you pay nothing for your<br/>covered Part D drugs.</b> |

## SECTION 1 Changes to Benefits & Costs for Next Year

### Section 1.1 Changes to the Monthly Plan Premium

|                                                                                                                                                                                                                                                                                          | 2025<br>(this year) | 2026<br>(next year) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| <b>Monthly plan premium</b><br>(You must also continue to pay your Medicare Part B premium.)                                                                                                                                                                                             | \$0                 | \$15                |
| <b>Additional premium for optional supplemental benefits (Advantage Plus)</b><br>If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above.<br>(You must also continue to pay your Medicare Part B premium.) | \$21                | \$20                |

### Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about 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've paid this amount, you generally pay nothing for covered Part A and Part B services (and other health services not covered by Medicare) for the rest of the calendar year.

|                                                                                                                                                                                                                                         | 2025<br>(this year) | 2026<br>(next year)                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Maximum out-of-pocket amount</b>                                                                                                                                                                                                     | \$6,000             | \$6,000                                                                                                                                                                                                                   |
| Your costs for covered medical services (such as copayments) <b>count</b> toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount. |                     | <b>Once you've paid \$6,000 out of pocket for covered Part A and Part B services (and other health services not covered by Medicare), you'll pay nothing for your covered services for the rest of the calendar year.</b> |

## Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 Provider Directory [kp.org/directory](https://kp.org/directory) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at [kp.org/directory](https://kp.org/directory).
- Call Member Services at 1-800-443-0815 (TTY users call 711) to get current provider information or to ask us to mail you a Provider Directory.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-443-0815 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

## Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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 of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* ([kp.org/directory](https://kp.org/directory)) to see which pharmacies are in our network. Here's how to get an updated Pharmacy Directory:

- Visit our website at [kp.org/directory](https://kp.org/directory).
- Call Member Services at 1-800-443-0815 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-443-0815 (TTY users call 711) for help.

## Section 1.5 Changes to Benefits & Costs for Medical Services

|                                        | 2025<br>(this year)                    | 2026<br>(next year)                           |
|----------------------------------------|----------------------------------------|-----------------------------------------------|
| <b>Ambulance Services</b>              | You pay \$250 per one-way trip.        | <b>You pay \$300 per one-way trip.</b>        |
| <b>Cardiac Rehabilitation Services</b> | You pay \$15 per specialty care visit. | <b>You pay \$20 per specialty care visit.</b> |

### Dental Preventive and Comprehensive Services

Through our agreement with Delta Dental of California ("Delta Dental") and its DeltaCare® USA Medicare plan.

- Preventive

|                                                                   | 2025<br>(this year)                                                                                                                          | 2026<br>(next year)                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ○ X-Rays                                                          | <ul style="list-style-type: none"> <li>• Bitewings two per 12-month period.</li> <li>• Periapical x-rays</li> </ul>                          | <ul style="list-style-type: none"> <li>• <b>Bitewings one every calendar year.</b></li> <li>• <b>One panoramic radiographic image or comprehensive series every two calendar years.</b></li> <li>• <b>Two periapical x-rays every calendar year.</b></li> </ul> |
| ○ Cleanings                                                       | Prophylaxis or scaling in the presence of inflammation, two per 12-month period. Periodontal maintenance one treatment each 12-month period. | <b>Prophylaxis, scaling in the presence of inflammation, or periodontal maintenance, two every calendar year.</b>                                                                                                                                               |
| ○ Other Diagnostic                                                | Assessment of salivary flow is covered once every 12 months.                                                                                 | <b>Not Covered.</b>                                                                                                                                                                                                                                             |
| <ul style="list-style-type: none"> <li>• Comprehensive</li> </ul> |                                                                                                                                              |                                                                                                                                                                                                                                                                 |
| ○ Periodontics                                                    | Periodontal scaling and root planing are limited to 4 quadrants during any 12 consecutive months.                                            | <b>Periodontal scaling and root planing are covered once per quadrant every two calendar years.</b>                                                                                                                                                             |
| ○ Adjunctive Services                                             | Not Covered.                                                                                                                                 | <b>You pay \$0 for palliative treatment of dental pain, once per day.</b>                                                                                                                                                                                       |
| <b>Dental Services – Medicare-Covered</b>                         | You pay \$15 per visit with a specialist.                                                                                                    | <b>You pay \$20 per visit with a specialist.</b>                                                                                                                                                                                                                |
| <b>Emergency Department</b>                                       | You pay \$125 per visit.                                                                                                                     | <b>You pay \$130 per visit.</b>                                                                                                                                                                                                                                 |
| <b>Eye Exams – Medicare-Covered</b>                               | You pay \$15 per visit with an ophthalmologist.                                                                                              | <b>You pay \$20 per visit with an ophthalmologist.</b>                                                                                                                                                                                                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2025<br>(this year)                                   | 2026<br>(next year)                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hearing Exams – Medicare-Covered</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | You pay \$15 per visit.                               | You pay \$20 per visit.                                                                                                                                                       |
| <p><b>Home medical care not covered by Medicare (Advanced Care At Home)</b></p> <p>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 and post-acute care services in the home to support your recovery, including the following services and items <b>in accord with your home treatment plan (referral required):</b></p> <ul style="list-style-type: none"> <li>• Communication devices to allow for member contact with our network provider's command center 24 hours a day, 7 days a week.</li> <li>• Certain equipment to ensure appropriate member monitoring in the home.</li> <li>• Certain safety items.</li> <li>• Meals while receiving acute care in the home. Up to 21 meals will be provided per week in accord with treatment plan, for as long as they are prescribed by a network hospitalist.</li> </ul> | Not Covered.                                          | <b>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).</b> |
| <ul style="list-style-type: none"> <li>• Certain Medicare-covered services and items, including, but not limited</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | You pay the applicable cost-sharing described in your | <b>You pay \$0 when prescribed as part of your home treatment plan,</b>                                                                                                       |

|                                                                                                                                                                       | 2025<br>(this year)                                                                                                                                                                                  | 2026<br>(next year)                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| to, acute care, emergency department visits, home visits by certain healthcare professionals, imaging and tests such as X-rays, labs, and EKGs, and medical supplies. | Evidence of Coverage, Chapter 4, Medical Benefits Chart.                                                                                                                                             | <b>otherwise you pay the applicable cost share (see the Evidence of Coverage, Chapter 4, Medical Benefits Chart, for details).</b>                                            |
| <b>Inpatient Acute Care</b>                                                                                                                                           | Per admission, you pay \$245 per day for days 1–5 (\$0 for the rest of your stay).                                                                                                                   | <b>Per admission, you pay \$320 per day for days 1–5 (\$0 for the rest of your stay).</b>                                                                                     |
| <b>Inpatient Mental Health Care</b>                                                                                                                                   | Per admission, you pay \$245 per day for days 1–5 (\$0 for the rest of your stay).                                                                                                                   | <b>Per admission, you pay \$320 per day for days 1–5 (\$0 for the rest of your stay).</b>                                                                                     |
| <b>Medicare Part B Drugs – Generic</b><br>Up to a 30-day supply from a network pharmacy                                                                               | You pay \$12 per prescription.                                                                                                                                                                       | <b>You pay \$10 per prescription.</b>                                                                                                                                         |
| <b>Medicare Part B Insulin Drugs – Brand-name</b><br>Up to a 30-day supply from a network pharmacy                                                                    | You pay \$25 per prescription.                                                                                                                                                                       | <b>You pay \$35 per prescription.</b>                                                                                                                                         |
| <b>Medicare Part B Insulin Drugs – Generic</b><br>Up to a 30-day supply from a network pharmacy                                                                       | You pay \$0.                                                                                                                                                                                         | <b>You pay \$10 per prescription.</b>                                                                                                                                         |
| <b>MRI, CT, and PET</b>                                                                                                                                               | You pay \$225 per procedure.                                                                                                                                                                         | <b>You pay \$275 per procedure.</b>                                                                                                                                           |
| <b>Observation Services</b>                                                                                                                                           | You pay \$0 when transferred for observation from an Emergency Department or following outpatient surgery or \$125 per stay when admitted directly to the hospital for observation as an outpatient. | <b>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</b> |

|                                                                | 2025<br>(this year)                                                                                                                  | 2026<br>(next year)                                                                                                                                                                                                                  |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                                                                                                                      | <b>observation as an outpatient.</b>                                                                                                                                                                                                 |
| <b>Occupational Therapy Services</b>                           | You pay \$0.                                                                                                                         | <b>You pay \$7 per group visit or \$15 per individual visit.</b>                                                                                                                                                                     |
| <b>Outpatient Hospital Services</b>                            | You pay \$0 or \$180 per visit, depending on the service.                                                                            | <b>You pay \$0 or \$300 per visit, depending on the service.</b>                                                                                                                                                                     |
| <b>Outpatient Surgery in an Ambulatory Surgical Center</b>     | You pay \$180 per procedure.                                                                                                         | <b>You pay \$300 per procedure.</b>                                                                                                                                                                                                  |
| <b>Over-the-Counter (OTC)</b>                                  | 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. | <b>Not Covered.</b>                                                                                                                                                                                                                  |
| <b>Physical Therapy and Speech-Language Pathology Services</b> | You pay \$0.                                                                                                                         | <b>You pay \$7 per group visit or \$15 per individual visit.</b><br><br><b>You pay \$15 per day for physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program.</b> |
| <b>Podiatry Services</b>                                       | You pay \$15 per visit.                                                                                                              | <b>You pay \$20 per visit.</b>                                                                                                                                                                                                       |
| <b>Skilled Nursing Facility (SNF) Care</b>                     | Per benefit period, you pay \$0 for days 1–20, \$100 per day for days 21–100.                                                        | <b>Per benefit period, you pay \$0 for days 1–20, \$150 per day for days 21–100.</b>                                                                                                                                                 |
| <b>Specialist Office Visits</b>                                | You pay \$15 per visit.                                                                                                              | <b>You pay \$20 per visit.</b>                                                                                                                                                                                                       |

|                                                                                                                                                                                                                    | 2025<br>(this year)                                       | 2026<br>(next year)                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------|
| <b>Optional supplemental benefits (Advantage Plus)</b><br><br>These changes only apply to members who have signed up for optional supplemental benefits, called Advantage Plus, for an additional monthly premium. |                                                           |                                                           |
| <ul style="list-style-type: none"> <li>Dental Benefits<br/>(Some dental services may have changed. Please refer to your <i>Evidence of Coverage</i> for complete details.)</li> </ul>                              |                                                           |                                                           |
| ○ Oral Exam                                                                                                                                                                                                        | You pay \$0 for two oral evaluations every calendar year. | <b>Not Covered.</b>                                       |
| ○ X-Rays                                                                                                                                                                                                           | You pay \$0 to \$214, depending on the service.           | <b>You pay \$0 to \$105, depending on the service.</b>    |
| ○ Other Preventive Dental Services                                                                                                                                                                                 | You pay \$0 to \$153, depending on the service.           | <b>You pay \$0.</b>                                       |
| ○ Restorative Services                                                                                                                                                                                             | You pay \$41 to \$533, depending on the service.          | <b>You pay \$18 to \$464, depending on the service.</b>   |
| ○ Endodontics                                                                                                                                                                                                      | You pay \$38 to \$492, depending on the service.          | <b>You pay \$25 to \$625, depending on the service.</b>   |
| ○ Periodontics                                                                                                                                                                                                     | You pay \$0 to \$518, depending on the service.           | <b>You pay \$15 to \$643, depending on the service.</b>   |
| ○ Prophylaxis                                                                                                                                                                                                      | You pay \$0.                                              | <b>Not Covered.</b>                                       |
| ○ Prosthodontics, removable                                                                                                                                                                                        | You pay \$41 to \$804, depending on the service.          | <b>You pay \$25 to \$738, depending on the service.</b>   |
| ○ Implant Services                                                                                                                                                                                                 | You pay \$0 to \$1,585, depending on the service.         | <b>You pay \$41 to \$2,000, depending on the service.</b> |
| ○ Prosthodontics, fixed                                                                                                                                                                                            | You pay \$70 to \$543, depending on the service.          | <b>You pay \$44 to \$528, depending on the service.</b>   |

|                                  | 2025<br>(this year)                               | 2026<br>(next year)                                     |
|----------------------------------|---------------------------------------------------|---------------------------------------------------------|
| ○ Oral and Maxillofacial Surgery | You pay \$0 to \$1,470, depending on the service. | <b>You pay \$53 to \$490, depending on the service.</b> |
| ○ Adjunctive General Services    | You pay \$0 to \$109, depending on the service.   | <b>You pay \$0 to \$151, depending on the service.</b>  |

## Section 1.6 Changes to Part D 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](http://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 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 calendar 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're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-443-0815 (TTY users call 711) for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you

about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call Member Services 1-800-443-0815 (TTY users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are 3 **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 no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

We have no deductible, so this payment stage doesn't apply to you.

- **Stage 2: Initial Coverage**

In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date out-of-pocket costs reach \$2,100.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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 don't count toward out-of-pocket costs.

### Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

|                          | 2025<br>(this year)                                                     | 2026<br>(next year)                                                            |
|--------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>Yearly Deductible</b> | Because we have no deductible, this payment stage doesn't apply to you. | <b>Because we have no deductible, this payment stage doesn't apply to you.</b> |

## Drug Costs in Stage 2: Initial 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. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

|                                                                                                                                                                                             | 2025<br>(this year)                                                                                                                                                   | 2026<br>(next year)                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 1 – Preferred generic drugs:</b><br>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.    | You pay \$3 per prescription. Your cost for a one-month mail-order prescription is \$3.                                                                               | <b>You pay \$0 per prescription. Your cost for a one-month mail-order prescription is \$0.</b>                                                                               |
| <b>Tier 2 – Generic drugs:</b><br>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.              | You pay \$12 per prescription. Your cost for a one-month mail-order prescription is \$12.                                                                             | <b>You pay \$0 per prescription. Your cost for a one-month mail-order prescription is \$0.</b>                                                                               |
| <b>Tier 3 – Preferred brand-name drugs:</b><br>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. | You pay \$47 per prescription. You pay \$25 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$47. | <b>You pay \$40 per prescription. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$40.</b> |

|                                                                                                                                                                                                 | 2025<br>(this year)                                                                         | 2026<br>(next year)                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <b>Tier 4 – Nonpreferred drugs:</b><br><br>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.         | You pay \$100 per prescription. Your cost for a one-month mail-order prescription is \$100. | <b>You pay \$90 per prescription. Your cost for a one-month mail-order prescription is \$90.</b> |
| <b>Tier 5 – Specialty-tier drugs:</b><br><br>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.       | You pay 33% of the total cost.                                                              | <b>You pay 33% of the total cost.</b>                                                            |
| <b>Tier 6 – Injectable Part D vaccines:</b><br><br>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. | You pay \$0 per prescription.                                                               | <b>You pay \$0 per prescription.</b>                                                             |

### Changes to the Catastrophic Coverage Stage

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

## SECTION 2 Administrative Changes

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2025<br>(this year)                                                                                                                                                                                                                                                                   | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Formulary exception for brand name drugs</b></p> <p>A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a <b>formulary exception</b>). If we agree to cover a Part D drug not on our Drug List, you will need to pay the cost-sharing amount specified on the right.</p> <p>For more information about how to file a formulary exception, please see the <i>Evidence of Coverage</i>.</p> | <p>If you request and we agree to cover a Part D brand-name drug not on our Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 for nonpreferred drugs.</p>                                                                                       | <p><b>If you request and we agree to cover a Part D brand-name drug not on our Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 5 specialty tier drugs.</b></p>                                                                                                                                  |
| <p><b>Medicare Prescription Payment Plan</b></p>                                                                                                                                                                                                                                                                                                                                                                                                  | <p>The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.</p> | <p><b>If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-800-443-0815 (TTY users call 711) or visit <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</b></p> |

## SECTION 3 How to Change Plans

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**To stay in Kaiser Permanente Senior Advantage Santa Clara County Basic plan, you don't need to do anything.** Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Senior Advantage Kaiser Permanente Senior Advantage Santa Clara County Basic plan.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Kaiser Permanente Senior Advantage Santa Clara County Basic plan.
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Kaiser Permanente Senior Advantage Santa Clara County Basic plan.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-800-443-0815 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit [www.Medicare.gov](http://www.Medicare.gov), check the Medicare & You 2026 handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Kaiser Permanente offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

### Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

## Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

## SECTION 4 Get Help Paying for Prescription Drugs

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You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the California AIDS Drug Assistance Program (ADAP). For information on

eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call the ADAP call center at 1-844-421-7050 between 8 a.m. and 5 p.m., Monday through Friday (excluding holidays). 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 payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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 the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-800-443-0815 (TTY users call 711) or visit [www.Medicare.gov](http://www.Medicare.gov).

## SECTION 5 Questions?

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### Get Help from Kaiser Permanente Senior Advantage Santa Clara County Basic plan

- **Call Member Services at 1-800-443-0815. (TTY users call 711.)**

We're available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

- **Read your 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Kaiser Permanente Senior Advantage Santa Clara County Basic plan. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at [kp.org/eocncal](http://kp.org/eocncal) or call Member Services at 1-800-443-0815 (TTY users call 711) to ask us to mail you a copy.

- **Visit [kp.org](http://kp.org)**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our List of Covered Drugs (formulary/Drug List).

## Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP).

Call the Health Insurance Counseling and Advocacy Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call the Health Insurance Counseling and Advocacy Program at 1-800-434-0222 (TTY users should call 711). Learn more about the Health Insurance Counseling and Advocacy Program by visiting [www.aging.ca.gov/HICAP/](http://www.aging.ca.gov/HICAP/).

## Get Help 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 can call 1-877-486-2048.

- **Chat live with [www.Medicare.gov](http://www.Medicare.gov)**

You can chat live at [www.Medicare.gov/talk-to-someone](http://www.Medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit [www.Medicare.gov](http://www.Medicare.gov)**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [www.Medicare.gov](http://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

## Notice of Language Assistance

**English: ATTENTION.** Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY 711), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY 711), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY 711), 24 hours a day, 7 days a week

**Arabic: تنبيه.** المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضاً طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815** (TTY 711)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY 711)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY 711)، 24 ساعة في اليوم، 7 أيام في الأسبوع

**Armenian: ՌԻՇՍԱԴՐՈՒԹՅՈՒՆ:** Լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP` 1-800-443-0815 (TTY 711), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal` 1-855-839-7613 (TTY 711), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը` 1-800-464-4000 (TTY 711), օրը 24 ժամ, շաբաթը 7 օր

**Chinese:** 请注意，我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

- Medicare, 包括 D-SNP : 1-800-443-0815 (TTY 711), 每周 7 天, 上午 8 点至晚上 8 点
- Medi-Cal : 1-855-839-7613 (TTY 711), 每周 7 天, 每天 24 小时
- 所有其他保险计划: 1-800-757-7585 (TTY 711), 每周 7 天, 每天 24 小时

**Farsi:** توجه. امکان بهره‌مندی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare, شامل D-SNP: با شماره 1-800-443-0815 (TTY 711) از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره 1-855-839-7613 (TTY 711)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره 1-800-464-4000 (TTY 711)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

**Hindi:** ध्यान दें। भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंग्वेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: 1-800-443-0815 (TTY 711), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: 1-855-839-7613 (TTY 711), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: 1-800-464-4000 (TTY 711), दिन के चौबीस घंटे, सप्ताह के 7 दिन

**Hmong:** FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab

rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnuv so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815 (TTY 711)**, 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnuv hauv ib lub vij
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 teev hauv ib hnuv, 7 hnuv hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000 (TTY 711)**, 24 teev hauv ib hnuv, 7 hnuv hauv ib lub vij

**Japanese:** ご注意。言語サポートは無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービスは主要な休日では営業していません。

- D-SNP を含む Medicare: **1-800-443-0815 (TTY 711)** 、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613 (TTY 711)** 、24 時間、年中無休
- その他全て: **1-800-464-4000 (TTY 711)** 、24 時間、年中無休

**Khmer (Cambodian):** យកចិត្តទុកដាក់។ ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្នាម សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare, រួមទាំង D-SNP: **1-800-443-0815 (TTY 711)** ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- Medi-Cal: **1-855-839-7613 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- ផ្សេងៗទៀត: **1-800-464-4000 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍

**Korean:** 안내 사항. 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815 (TTY 711)** 번으로 문의
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 주 7 일, 하루 24 시간
- 기타: **1-800-464-4000 (TTY 711)**, 주 7 일, 하루 24 시간

**Laotian: ໂປດຊາບ.** ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານ

ສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບ ແບບອື່ນ ເຊັ່ນ ອັກສອນນູນ,

ສຽງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ

ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ວັນຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

**Mien: CAU FIM JANGX LONGX OC.** Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih core haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hlou, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih core haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

**Navajo: GIHA.** Tséé' naalkáah sídá'ígíí éí doo t'ée' íí'í' dah sídáa'ígíí. T'ée' góó t'í'í'ígíí éí tséé' naalkáah sídá'ígíí bikáa' dah sídaa'ígíí, t'á'ii bik'eh dah na'álka'ígíí. T'á'ii éí t'ée' góó t'í'í'ígíí bik'eh dah deidiyós, t'á'ii éí bi'ée' bik'eh dah na'álka'ígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'álka'ígíí bikáa' dah na'álka'ígíí t'áa'altso bik'eh dah deidiyós. Bi'ée' naalkáah sídá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'álka'ígíí éí bik'eh dah naazhja'a'ígíí bik'eh dah na'álka'ígíí.

- Medicare, bikáa' dah deidiyós D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t'áálá'í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 t'ohch'oolí t'áálá'í jį, 7 jį t'áálá'í damóo
- T'áa' al'aq: **1-800-464-4000** (TTY **711**), 24 t'ohch'oolí t'áálá'í jį, 7 jį t'áálá'í damóo

**Punjabi: ਧਿਆਨ ਦਿਓ।** ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815 (TTY 711)**, ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000 (TTY 711)**, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

**Russian: ВНИМАНИЕ!** Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815 (TTY 711)**, без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000 (TTY 711)**, круглосуточно без выходных.

**Spanish: ATENCIÓN.** Se ofrece ayuda en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815 (TTY 711)**, los 7 días de la semana, de 8 a. m. a 8 p. m., los 7 días de la semana
- Medi-Cal: **1-855-839-7613 (TTY 711)**, las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616 (TTY 711)**, las 24 horas del día, los 7 días de la semana.

**Tagalog: PAUNAWA.** May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000 (TTY 711)**, 24 oras sa isang araw, 7 araw sa isang linggo

**Thai:** **ส่งถึง** มีบริการให้ความช่วยเหลือด้านภาษา แก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โปรดติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815 (TTY 711)** 8.00 น. ถึง 20.00 น. หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613 (TTY 711)** ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000 (TTY 711)** ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

**Ukrainian:** **УВАГА!** Послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів. Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815 (TTY 711)**, з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000 (TTY 711)**, цілодобово, без вихідних.

**Vietnamese:** **LƯU Ý.** Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp. Ban dịch vụ hội viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815 (TTY 711)**, 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000 (TTY 711)**, 24 giờ trong ngày, 7 ngày trong tuần.

## Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - ◆ Qualified sign language interpreters
  - ◆ Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- 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 our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 hours a day, 7 days a week.
- All others: **1-800-464-4000 (TTY 711)**, 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

### How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

**Attn: Kaiser Permanente Civil Rights Coordinator**  
Member Relations Grievance Operations  
P.O. Box 939001  
San Diego CA 92193

**How to file a grievance with the California Department of Health Care Services Office of Civil Rights** *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

Office of Civil Rights  
Department of Health Care Services  
P.O. Box 997413, MS 0009  
Sacramento, CA 95899-7413

**California Department of Health Care Services Office of Civil Rights Complaint forms are available at: [http://www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)**

- **Online:** Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov)

**How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights**

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office of Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

**U.S. Department of Health and Human Services Office of Civil Rights Complaint forms are available at: <https://www.hhs.gov/ocr/office/file/index.html>**

- **Online:** Visit the **Office of Civil Rights Complaint Portal** at: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

# Plan Information

*As a 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.*

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## Provider Directories

If you need help finding a network provider or pharmacy, please visit **kp.org/directory** to search our online directory (Note: the 2026 directories are available online starting 10/15/2025 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 **1-800-443-0815 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.

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## 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 2026 formulary is available online starting 10/15/2025 in accord with Medicare requirements).

To get a formulary mailed to you, you can call Kaiser Permanente at **1-800-443-0815 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.

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## 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/eocncal** or **kp.org/eocscal** to view your **EOC** online (Note: the 2026 **EOC** is available online starting 10/15/2025 in accord with Medicare requirements).

To get an **EOC** mailed to you, you can call Kaiser Permanente at **1-800-443-0815 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.



## Kaiser Permanente Senior Advantage Member Services

| Method  | Member Services – Contact Information                                                                                                                                                                                          |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Call    | <b>1-800-443-0815</b><br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.<br>Member Services 1-800-443-0815 (TTY users call 711) also has free language interpreter services available for non-English speakers. |
| TTY     | <b>711</b><br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.                                                                                                                                                   |
| Write   | Your local Member Services office (see the <i>Provider Directory</i> for locations).                                                                                                                                           |
| Website | <a href="http://kp.org">kp.org</a>                                                                                                                                                                                             |