

## Kaiser Permanente Senior Advantage Bronze DM (HMO-POS) offered by Kaiser Foundation Health Plan of Colorado (Bronze DM)

### Annual Notice of Change for 2026

You're enrolled as a member of Kaiser Permanente Senior Advantage Bronze DM.

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 Bronze DM.
- 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 1-800-476-2167 (TTY users call 711) to get a copy by mail.

#### More Resources

- Call Member Services at 1-800-476-2167 (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.

#### About Kaiser Permanente Senior Advantage Bronze DM

- Kaiser Permanente is an HMO-POS 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 of Colorado (Health Plan). When it says “plan” or “our plan,” it means Kaiser Permanente Senior Advantage Bronze DM (Senior Advantage).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Kaiser Permanente Senior Advantage Bronze DM.** Starting January 1, 2026, you'll get your medical and drug coverage through Kaiser Permanente Senior Advantage Bronze DM. Go to Section 3 for more information about how to change plans and deadlines for making a change.

## Table of Contents

|                                                                       |           |
|-----------------------------------------------------------------------|-----------|
| <b>Summary of Important Costs for 2026 .....</b>                      | <b>3</b>  |
| <b>SECTION 1 Changes to Benefits &amp; Costs for Next Year .....</b>  | <b>5</b>  |
| Section 1.1 Changes to the Monthly Plan Premium .....                 | 5         |
| Section 1.2 Changes to Your Maximum Out-of-Pocket Amount .....        | 6         |
| Section 1.3 Changes to the Provider Network .....                     | 6         |
| Section 1.4 Changes to the Pharmacy Network.....                      | 7         |
| Section 1.5 Changes to Benefits & Costs for Medical Services .....    | 7         |
| Section 1.6 Changes to Part D Drug Coverage .....                     | 12        |
| Section 1.7 Changes to Prescription Drug Benefits & Costs .....       | 13        |
| <b>SECTION 2 Administrative Changes .....</b>                         | <b>16</b> |
| <b>SECTION 3 How to Change Plans.....</b>                             | <b>17</b> |
| Section 3.1 Deadlines for Changing Plans.....                         | 17        |
| Section 3.2 Are there other times of the year to make a change? ..... | 18        |
| <b>SECTION 4 Get Help Paying for Prescription Drugs .....</b>         | <b>18</b> |
| <b>SECTION 5 Questions? .....</b>                                     | <b>19</b> |
| Get Help from Kaiser Permanente Senior Advantage Bronze DM.....       | 19        |
| Get Free Counseling about Medicare .....                              | 20        |
| Get Help from Medicare .....                                          | 20        |

## 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 than this amount. Go to Section 1.1 for details.                                                                                                                                                                                                                        | \$0                                                                        | \$0                                                                        |
| <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.)                                                                                                                                                                     | \$5,900                                                                    | \$5,900                                                                    |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                                                                                    | \$0                                                                        | \$0                                                                        |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                                                                                      | \$35 per visit.                                                            | \$35 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 discharged is your last inpatient day. | Per admission, \$250 per day for days 1–5 (\$0 for the rest of your stay). | Per admission, \$350 per day for days 1–6 (\$0 for the rest of your stay). |

|                                                                                                                                                  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part D drug coverage deductible</b><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>Preferred cost sharing during the Initial Coverage Stage:</p> <p>Drug Tier 1: \$0</p> <p>Drug Tier 2: \$3</p> <p>Drug Tier 3: \$45</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: \$90</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5: 33%</p> <p>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>During this payment stage, you pay nothing for your covered Part D drugs.</p> | <p><b>Preferred cost sharing during the Initial Coverage Stage:</b></p> <p><b>Drug Tier 1: \$0</b></p> <p><b>Drug Tier 2: \$7</b></p> <p><b>Drug Tier 3: \$45</b></p> <p><b>You pay \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 4: \$90</b></p> <p><b>You pay \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 5: 33%</b></p> <p><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> <p><b>During this payment stage, you pay nothing for your covered Part D drugs.</b></p> |

## 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                 | \$0                 |
| <b>Additional premium for optional supplemental benefits (Advantage Plus Option 1)</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.) | \$44                | \$45                |
| <b>Additional premium for optional supplemental benefits (Advantage Plus Option 2)</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.) | \$14                | \$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.

## 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><br>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. | \$5,900             | <b>\$5,900</b><br><b>Once you've paid \$5,900 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 1-800-476-2167 (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 1-800-476-2167 (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 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.

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 1-800-476-2167 (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 1-800-476-2167 (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>Chiropractic Services</b>                                                                                                                             | You pay \$20 per visit.                                                                                                                                                      | <b>You pay \$15 per visit.</b>                                                                                                                                            |
| <b>Dental Services</b><br>Preventive and comprehensive dental services<br>Please see the <i>Evidence of Coverage</i> for a full list of dental services. | The plan pays \$2,350 (combined annual benefit limit) for preventive and comprehensive dental care provided by Delta Dental Medicare Advantage PPO and/or Medicare Advantage | <b>The plan pays \$2,000 (combined annual benefit limit) for preventive and comprehensive dental care provided by Delta Dental Medicare Advantage PPO and/or Medicare</b> |

|                                                         | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                       | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                         | <p>Premier dentists until the plan has paid the annual limit.</p> <p>When you reach the annual limit, you pay 100% for the rest of the year.</p> <p>Note: The maximum benefit limit for Delta Dental Medicare Advantage Premier dentists may not exceed \$500.</p> <p>There is no coverage for Non-Participating dentists.</p> <p>Additional coverage is available if you enroll in Advantage Plus 1.</p> | <p><b>Advantage Premier dentists until the plan has paid the annual limit.</b></p> <p><b>When you reach the annual limit, you pay 100% for the rest of the year.</b></p> <p><b>Note: There is no coverage for Non-Participating dentists.</b></p> <p><b>Additional coverage is available if you enroll in Advantage Plus 1.</b></p> |
| • Adjunctive Services                                   | You pay 50% coinsurance.                                                                                                                                                                                                                                                                                                                                                                                  | <b>You pay 50% coinsurance or \$0 for palliative treatment of dental pain (D9110).</b>                                                                                                                                                                                                                                              |
| • Implant Services                                      | You pay 50% coinsurance.                                                                                                                                                                                                                                                                                                                                                                                  | <b>Not Covered.</b>                                                                                                                                                                                                                                                                                                                 |
| • Periodontics                                          | You pay 50% coinsurance.                                                                                                                                                                                                                                                                                                                                                                                  | <b>You pay 50% coinsurance or \$0 for periodontal maintenance (D4910) and scaling in the presence of generalized moderate or severe gingival inflammation (D4346).</b>                                                                                                                                                              |
| • Restorative Services                                  | You pay 30% to 50% coinsurance, depending on the service.                                                                                                                                                                                                                                                                                                                                                 | <b>You pay 50% coinsurance.</b>                                                                                                                                                                                                                                                                                                     |
| <b>DME and Medical Supplies not covered by Medicare</b> |                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                     |
| • Oxygen concentrator rental for nighttime home use     | You pay 20% coinsurance. Requires an in-lab titration study performed prior to prescription if deemed                                                                                                                                                                                                                                                                                                     | <b>You pay 20% coinsurance. Must be deemed medically appropriate by sleep medicine provider</b>                                                                                                                                                                                                                                     |

|                                    | 2025<br>(this year)                                                                                                                                                                                                                                                                                | 2026<br>(next year)                                                                                                                                                                                                                                                                                           |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                    | medically appropriate by sleep medicine provider for obstructive sleep apnea.                                                                                                                                                                                                                      | <b>for obstructive sleep apnea. In-lab titration study is no longer required.</b>                                                                                                                                                                                                                             |
| <b>Emergency Department</b>        | You pay \$125 per visit.                                                                                                                                                                                                                                                                           | <b>You pay \$130 per visit.</b>                                                                                                                                                                                                                                                                               |
| <b>Eyewear Allowance</b>           | You receive a \$550 allowance every 12 months. If the eyewear you purchase costs more than your allowance, you pay the difference. Additional coverage is available if you enroll in Advantage Plus 1.                                                                                             | <b>You receive a \$500 allowance every 12 months. If the eyewear you purchase costs more than your allowance, you pay the difference. Additional coverage is available if you enroll in Advantage Plus 1.</b>                                                                                                 |
| <b>Fitness Allowance</b>           | You receive an annual (one calendar year) allowance of up to \$500.                                                                                                                                                                                                                                | <b>Not Covered.</b><br><b>Note: You still have access to a fitness benefit with gym membership. See your Evidence of Coverage for more information.</b>                                                                                                                                                       |
| <b>Hearing Aids - Prescription</b> | You receive a \$700 hearing aid allowance per ear every 2 years. If the hearing aid(s) you purchase costs more than your allowance, you pay the difference.<br>Note: This hearing aid benefit may not be available next year.<br>Additional coverage is available if you enroll in Advantage Plus. | <b>You receive a \$550 hearing aid allowance per ear every 2 years. If the hearing aid(s) you purchase costs more than your allowance, you pay the difference.</b><br><b>Note: This hearing aid benefit may not be available next year. Additional coverage is available if you enroll in Advantage Plus.</b> |
| <b>Inpatient Acute Care</b>        | You pay \$250 per day for days 1–5 (\$0 for the rest of your stay).                                                                                                                                                                                                                                | <b>You pay \$350 per day for days 1–6 (\$0 for the rest of your stay).</b>                                                                                                                                                                                                                                    |

|                                                                                                                                               | 2025<br>(this year)                                                 | 2026<br>(next year)                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Inpatient Mental Health Care</b>                                                                                                           | You pay \$250 per day for days 1–5 (\$0 for the rest of your stay). | <b>You pay \$350 per day for days 1–6 (\$0 for the rest of your stay).</b> |
| <b>Medicare Explorer by Kaiser Permanente (point-of-service supplemental benefit)</b><br><br>See the <i>Evidence of Coverage</i> for details. |                                                                     |                                                                            |
| • <b>Chiropractic Services</b>                                                                                                                | You pay \$20 per specialty care visit.                              | <b>You pay \$15 per specialty care visit.</b>                              |
| • <b>Ultrasounds</b>                                                                                                                          | You pay \$50 per ultrasound.                                        | <b>You pay \$80 per ultrasound.</b>                                        |
| <b>Medicare Part B Drugs - Generic</b><br>Up to a 30-day supply from a network pharmacy.                                                      | You pay \$3 per prescription.                                       | <b>You pay \$7 per prescription.</b>                                       |
| <b>Medicare Part B Insulin Drugs- Generic</b><br>Up to a 30-day supply from a network pharmacy                                                | You pay \$3 per prescription.                                       | <b>You pay \$7 per prescription.</b>                                       |
| <b>MRI, CT, and PET</b>                                                                                                                       | You pay \$140 per procedure, per body part studied.                 | <b>You pay \$350 per procedure, per body part studied.</b>                 |
| <b>Outpatient Hospital Services</b>                                                                                                           | You pay \$250 per outpatient surgery.                               | <b>You pay \$350 per outpatient surgery.</b>                               |
| <b>Outpatient Surgery in an Ambulatory Surgical Center</b>                                                                                    | You pay \$150 per outpatient surgery.                               | <b>You pay \$185 per outpatient surgery.</b>                               |

|                                                                                                                                           | 2025<br>(this year)                                                                                                                   | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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 \$120 quarterly benefit limit. | <b>You will receive a preloaded healthy extras card with a quarterly benefit limit of \$40 to purchase eligible OTC items online and at participating retail stores. Your card will be reloaded on January 1, April 1, July 1, and October 1 on the 1st of each month. Any unused portion of the quarterly benefit limit doesn't roll over to the next quarter.</b> |
| <b>Referrals from your PCP</b><br>Referrals are needed from your PCP before you can get care for the following Medicare-covered services: |                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li><b>Specialist Office Visits</b></li> </ul>                                                         | Referral only applies to allergy, dermatology and urology specialists.                                                                | <b>Referral only applies to Allergy, Dermatology, Urology, Neurology, General Surgery, Endocrinology, Pulmonology, Neurosurgery, Physiatry/Physical Medicine and Rehab (PM&amp;R), and Head and Neck Surgery.</b>                                                                                                                                                   |
| <b>Skilled Nursing Facility (SNF) Care</b>                                                                                                | Per benefit period, you pay \$0 for days 1–20, \$203 per day for days 21–41 and \$0 for days 42–100.                                  | <b>Per benefit period, you pay \$0 for days 1–20, \$203 per day for days 21–50 and \$0 for days 51–100.</b>                                                                                                                                                                                                                                                         |
| <b>Ultrasounds</b>                                                                                                                        | You pay \$50 per ultrasound.                                                                                                          | <b>You pay \$80 per ultrasound.</b>                                                                                                                                                                                                                                                                                                                                 |

|                                                                                                                                                               | 2025<br>(this year)                                       | 2026<br>(next year)             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------|
| <b>Optional supplemental benefits<br/>(Advantage Plus Option 1)</b>                                                                                           |                                                           |                                 |
| This change only applies to members who have signed up for optional supplemental benefits, called Advantage Plus Option 1, for an additional monthly premium. |                                                           |                                 |
| <b>Dental Comprehensive</b>                                                                                                                                   |                                                           |                                 |
| • Restorative                                                                                                                                                 | You pay 30% to 50% coinsurance, depending on the service. | <b>You pay 50% coinsurance.</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](https://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 1-800-476-2167 (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 at 1-800-476-2167 (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

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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; at a network pharmacy that offers preferred cost sharing; 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><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. | Standard cost sharing:<br>You pay \$15 per prescription.<br><br>Preferred cost sharing:<br>You pay \$0 per prescription.                          | <b>Standard cost-sharing:<br/>           You pay \$15 per prescription.</b><br><br><b>Preferred cost-sharing:<br/>           You pay \$0 per prescription.</b>                                                             |
| <b>Tier 2 – Generic 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.           | Standard cost-sharing:<br>You pay \$20 per prescription.<br><br>Preferred cost-sharing:<br>You pay \$3 per prescription.<br>You pay \$3 per month | <b>Standard cost-sharing:<br/>           You pay \$20 per prescription.</b><br><br><b>Preferred cost-sharing:<br/>           You pay \$7 per prescription.<br/>           You pay \$7 per month supply of each covered</b> |

|                                                                                                                                                                                                 | 2025<br>(this year)                                                                                                        | 2026<br>(next year)                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                 | supply of each covered insulin product on this tier.                                                                       | insulin product on this tier.                                                                                                                          |
| <b>Tier 3 – Preferred brand-name 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. | Standard cost-sharing:<br>You pay \$47 per prescription.<br><br>Preferred cost-sharing:<br>You pay \$45 per prescription.  | <b>Standard cost-sharing:</b><br><b>You pay \$47 per prescription.</b><br><br><b>Preferred cost-sharing:</b><br><b>You pay \$45 per prescription.</b>  |
| <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.         | Standard cost-sharing:<br>You pay \$100 per prescription.<br><br>Preferred cost-sharing:<br>You pay \$90 per prescription. | <b>Standard cost-sharing:</b><br><b>You pay \$100 per prescription.</b><br><br><b>Preferred cost-sharing:</b><br><b>You pay \$90 per prescription.</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.                                                                                             | You pay 33% of the total cost.                                                                                                                         |
| <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.                                                                                              | You pay \$0 per prescription.                                                                                                                          |

## 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</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 1-800-476-2167 (TTY users</b></p> |

|  | 2025<br>(this year)                   | 2026<br>(next year)                                                         |
|--|---------------------------------------|-----------------------------------------------------------------------------|
|  | participating in this payment option. | call 711) or visit <a href="http://www.Medicare.gov">www.Medicare.gov</a> . |

## SECTION 3 How to Change Plans

**To stay in Kaiser Permanente Senior Advantage Bronze DM, 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 Kaiser Permanente Senior Advantage Bronze DM.

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 Bronze DM.
- **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 Bronze DM.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-800-476-2167 (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.
- **Help from your state's pharmaceutical assistance program (SPAP).** Colorado has a program called Bridging the Gap Colorado that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the

program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [shiphelp.org](http://shiphelp.org), or call 1-800-MEDICARE.

- **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 Bridging the Gap Colorado. 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 Bridging the Gap Colorado at 1-303-692-2716. 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 SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-800-476-2167 (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 Bronze DM

- **Call Member Services at 1-800-476-2167. (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 Bronze DM. 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/eocco](https://kp.org/eocco) or call Member Services at 1-800-476-2167 (TTY users call 711) to ask us to mail you a copy.

- **Visit [kp.org](https://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 Colorado, the SHIP is called Colorado State Health Insurance Assistance Program.

Call Colorado State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Colorado State Health Insurance Assistance Program at 1-888-696-7213. Learn more about Colorado State Health Insurance Assistance Program by visiting [www.colorado.gov/pacific/dora/senior-healthcare-medicare](https://www.colorado.gov/pacific/dora/senior-healthcare-medicare).

## **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](https://www.Medicare.gov)**

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



## Kaiser Permanente Senior Advantage Member Services

| Method  | Member Services – Contact Information                                                                                                                                                                                          |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Call    | <b>1-800-476-2167</b><br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.<br>Member Services 1-800-476-2167 (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   | Kaiser Permanente<br>10350 East Dakota Ave.<br>Denver, CO 80247                                                                                                                                                                |
| Website | <a href="http://kp.org">kp.org</a>                                                                                                                                                                                             |

## NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary 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, braille, and accessible electronic formats
- Provides 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 **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, age, disability, sex, (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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**, (TTY **1-800-537-7697**). Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

This notice is available at

<https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice>

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## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-632-9700** (TTY **711**).

**አማርኛ (Amharic) ትኩረት፡** አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** ይደውሉ (TTY **711**)።

**العربية (Arabic) (تنبيه):** إذا كنت تتحدث اللغة العربية فتستفيد من خدمات المساعدة اللفظية. يمكنك الاتصال بـ **1-800-632-9700** (TTY **711**) للحصول على المساعدة.

**Baśòò Wùdù (Bassa) Mbi sog:** nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsorj ni sorj, ninj ma kénjén yé, mbi èyem. Wò nànj **1-800-632-9700** (TTY **711**)

**中文 (Chinese) 注意事項:** 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-632-9700** (TTY **711**)。

**فارسی (Farsi) (توجه):** گریبه زبان فارسی صحبت میکنید، به سئوالات زیری، از جمله کمک ها و خدمات پشتیبانی فیلسب به صورت رایگان در دسترسیتان میباشد **1-800-632-9700** (TTY **711**) (تلفنگیری).

**Français (French) ATTENTION:** si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-632-9700** (TTY **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (TTY **711**).

**Igbo (Igbo) TINYE UCHE:** Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesiri ekwesị, n'efu, dị nye gị. Kpọọ **1-800-632-9700** (TTY **711**).

**日本語 (Japanese) 注意:** 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-800-632-9700** までお電話ください (TTY : **711**)。

**한국어 (Korean) 주의:** 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-632-9700** 로 전화해 주세요 (TTY **711**).

**Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN:** Díí saad bee yánítí'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áa jiik'eh, éí ná hóló, koji' hódíílnih **1-800-632-9700** (TTY **711**).

**नेपाली (Nepali) ध्यान दिनुहोस्:** यदि तपाईं नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन **1-800-632-9700** (TTY: **711**)।

**Afaan Oromoo (Oromo) XIYYEEFFANNOO:** Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (TTY **711**)

**Русский (Russian) ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-632-9700** (TTY **711**).

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-632-9700** (TTY **711**).

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-632-9700 (TTY 711)**.

**Yorùbá (Yoruba) ÀKÍYÈSÍ:** Tí o bá ń sọ èdè Yorùbá, àwọn isẹ̀ ìrànlowọ̀ èdè tó fì kún àwọn ohun èlò ìrànlowọ̀ tó yẹ àti àwọn isẹ̀ láisí ìdíyelé wà fún ọ. Pe **1-800-632-9700 (TTY 711)**.

# 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** or **Pharmacy Directory** mailed to you, you can call Kaiser Permanente at **1-800-476-2167 (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 **1-800-476-2167 (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/eocco** 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 **1-800-476-2167 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.