Providence Medicare Choice + Rx (HMO-POS) offered by Providence Health Assurance

Annual Notice of Changes for 2025

You are currently enrolled as a member of Providence Medicare Choice + Rx (HMO-POS). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules, please review the *Evidence of Coverage*, which is located on our website at www.ProvidenceHealthAssurance.com/EOC. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital)
- Review the changes to our drug coverage, including coverage restrictions and costs sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

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

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

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

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

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

Additional Resources

- Please contact our Customer Service number at 503-574-8000 or 1-800-603-2340 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week. This call is free.
- This information is available in multiple formats, including large print and braille.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Providence Medicare Choice + Rx (HMO-POS)

- Providence Health Assurance is an HMO, HMO-POS and HMO SNP with Medicare and Oregon Health Plan contracts. Enrollment in Providence Health Assurance depends on contract renewal.
- When this document says "we," "us," or "our," it means Providence Health Assurance. When it says "plan" or "our plan," it means Providence Medicare Choice + Rx (HMO-POS).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Providence Medicare Choice + Rx (HMO-POS) in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$71	$82
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$4,500 when using your in-network benefit. $10,000 when using your Point-of-Service (POS) benefit.	$5,000 when using your in-network benefit. No maximum when using your Point-of-Service (POS) benefit.
Doctor office visits	Primary care visits in-network: $15 copayment per visit. Primary care visits when using your POS benefit: $25 copayment per visit. Specialist visits in-network: $30 copayment per visit. Specialist visits when using your POS benefit: $50 copayment per visit.	Primary care visits in-network: $15 copayment per visit. Primary care visits when using your POS benefit: $25 copayment per visit. Specialist visits in-network: $30 copayment per visit. Specialist visits when using your POS benefit: $50 copayment per visit.

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	Hospital stays in-network: $300 copayment each day for days 1-6 per admission and there is no coinsurance, copayment, or deductible for day 7 and beyond for Medicare-covered inpatient hospital care. Hospital stays when using your POS benefit: 20% of the total cost per admission for Medicare-covered inpatient hospital care.	Hospital stays in-network: $300 copayment each day for days 1-6 per admission and there is no coinsurance, copayment, or deductible for day 7 and beyond for Medicare-covered inpatient hospital care. Hospital stays when using your POS benefit: 20% of the total cost per admission for Medicare-covered inpatient hospital care.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 per prescription at a preferred network pharmacy or $14 per prescription at a network pharmacy. • Drug Tier 2: $10 per prescription at a preferred network pharmacy or $20 per prescription at a network pharmacy.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 per prescription at a preferred network pharmacy or $14 per prescription at a network pharmacy. • Drug Tier 2: $10 per prescription at a preferred network pharmacy or $20 per prescription at a network pharmacy.

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 3: $37 per prescription at a preferred network pharmacy or $37 per prescription at a network pharmacy. You pay up to a $35 copayment for each prescription filled, up to a 30-day supply of each covered insulin product on this tier.	• Drug Tier 3: $40 per prescription at a preferred network pharmacy or $47 per prescription at a network pharmacy. You pay $35 per month supply of each covered insulin product on this tier.
	• Drug Tier 4: $100 per prescription at a preferred network pharmacy or $100 per prescription at a network pharmacy. You pay up to a $35 copayment for each prescription filled, up to a 30-day supply of each covered insulin product on this tier.	• Drug Tier 4: $100 per prescription at a preferred network pharmacy or $100 per prescription at a network pharmacy. You pay $35 per month supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 5: 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a network pharmacy. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs **and for excluded drugs that are covered under our enhanced benefit.** You pay nothing.	• Drug Tier 5: 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a network pharmacy. Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs **and for excluded drugs that are covered under our enhanced benefit.**

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$71	$82
Optional Supplemental Dental Coverage monthly premium	Providence Dental Basic $33.00	Providence Dental Basic $37.50
Optional Supplemental Dental Coverage monthly premium	Providence Dental Enhanced $45.00	Providence Dental Enhanced $53.50

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

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,500 In-Network $10,000 Out-of-Network	$5,000 In-Network No maximum Out-of-Network Once you have paid $5,000 out-of-pocket for covered services from in-network providers, you will pay nothing for your in-network covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at www.ProvidenceHealthAssurance.com/findaprovider. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider and Pharmacy Directory*** www.ProvidenceHealthAssurance.com/findaprovider **to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2025 *Provider and Pharmacy Directory* to see which pharmacies are in our network**.

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2024 (this year)	2025 (next year)
Ambulance	You pay a $250 copayment per one-way Medicare-covered ground ambulance transport. You pay a $250 copayment per one-way Medicare-covered air ambulance transport.	You pay a $275 copayment per one-way Medicare-covered ground ambulance transport. You pay a $275 copayment per one-way Medicare-covered air ambulance transport.
Emergency care	**In-Network and Out-of-Network** You pay a $90 copayment for each Medicare-covered emergency room visit.	**In-Network and Out-of-Network** You pay a $125 copayment for each Medicare-covered emergency room visit.
Health and wellness education programs	**In-Network** There is no coinsurance, copayment, or deductible for health and wellness classes.	**In-Network** Health and wellness classes are not covered.
Outpatient hospital services	**In-Network** You pay a $90 copayment for each Medicare-covered emergency room visit. You pay a $250 copayment for each Medicare-covered outpatient hospital surgical service. **Out-of-Network** You pay a $90 copayment for each Medicare-covered emergency room visit when using your POS benefit.	**In-Network** You pay a $125 copayment for each Medicare-covered emergency room visit. You pay a $350 copayment for each Medicare-covered outpatient hospital surgical service. **Out-of-Network** You pay a $125 copayment for each Medicare-covered emergency room visit when using your POS benefit.

Cost	2024 (this year)	2025 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay a $250 copayment for each Medicare-covered outpatient hospital surgical service.	**In-Network** You pay a $350 copayment for each Medicare-covered outpatient hospital surgical service.
Over-the-counter (OTC) items	Over-the-counter items are not covered.	You receive a pre-loaded debit card with an allowance of $30 every three months, which you may use to purchase approved over-the-counter items. Over-the-counter items must be provided and arranged through authorized vendor or approved retailers.
Skilled nursing facility (SNF) care	**In-Network** There is no coinsurance, copayment, or deductible for days 1-20 of a benefit period for Medicare-covered SNF care. You pay a $160 copayment each day for days 21-100 of a benefit period for Medicare-covered SNF care.	**In-Network** There is no coinsurance, copayment, or deductible for days 1-20 of a benefit period for Medicare-covered SNF care. You pay a $214 copayment each day for days 21-100 of a benefit period for Medicare-covered SNF care.
Worldwide emergency/urgent care	**In-Network and Out-of-Network** You pay a $90 copayment for each Medicare-covered emergency room visit. You pay a $250 copayment for Worldwide Emergency Transportation.	**In-Network and Out-of-Network** You pay a $125 copayment for each Medicare-covered emergency room visit. You pay a $275 copayment for Worldwide Emergency Transportation.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

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

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

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

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

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

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We have included a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the *LIS Rider*.

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

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

Changes to the Deductible Stage

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

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**.	Your cost for a one-month supply is:	Your cost for a one-month supply is:
We changed the tier for some of the drugs on our "Drug List". To see if your drugs will be in a different tier, look them up on the "Drug List".	**Tier 1 Preferred Generic:** *Standard cost sharing:* You pay $14 per prescription.	**Tier 1 Preferred Generic:** *Standard cost sharing:* You pay $14 per prescription.

Stage	2024 (this year)	2025 (next year)
	Preferred cost sharing: You pay $0 per prescription.	*Preferred cost sharing:* You pay $0 per prescription.
Most adult Part D vaccines are covered at no cost to you.	**Tier 2 Generic:** *Standard cost sharing:* You pay $20 per prescription. *Preferred cost sharing:* You pay $10 per prescription. Your cost for a one-month mail-order prescription is $10.	**Tier 2 Generic:** *Standard cost sharing:* You pay $20 per prescription. *Preferred cost sharing:* You pay $10 per prescription. Your cost for a one-month mail-order prescription is $0.
	Tier 3 Preferred Brand: *Standard cost sharing:* You pay $37 per prescription. *Preferred cost sharing:* You pay $37 per prescription. Your cost for a one-month mail-order prescription is $37.	**Tier 3 Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $40 per prescription. Your cost for a one-month mail-order prescription is $40.
	Tier 4 Non-Preferred Brand: *Standard cost sharing:* You pay $100 per prescription.	**Tier 4 Non-Preferred Drug:** *Standard cost sharing:* You pay $100 per prescription.
	Preferred cost sharing: You pay $100 per prescription.	*Preferred cost sharing:* You pay $100 per prescription.

Stage	2024 (this year)	2025 (next year)
	Tier 5 Specialty: *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 Specialty:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. _____ Once you have paid $2,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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

SECTION 2 Administrative Changes

Administrative changes may be strictly informational, with little to no impact on your benefits, or they may change how you access your care and which services and prescription drugs are available to you. The table below lists the administrative changes we are making for next year.

Description	2024 (this year)	2025 (next year)
Customer Service TTY (non-member)	1-800-457-6064 (TTY: 711)	1-800-457-6064 (TTY: 711 1-800-855-7100)

Customer Service TTY for Prospective Medicare Beneficiaries	(800) 735-2900	711
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 855-742-2779 or visit Medicare.gov.
Part D Insulin	Up to 100-day supply for $35 at Mail Order or Preferred Retail Pharmacy.	Up to 30-day supply for $35, 60-day supply for $70, and 100-day supply for $95 at Mail Order and $105 at Retail.
Part D Tier 2 Generic Mail Order Copay	Up to 100-day supply for $10.	Up to 100-day supply for $0.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Providence Medicare Choice + Rx (HMO-POS)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Providence Medicare Choice + Rx (HMO-POS).

Section 3.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

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

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

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Providence Medicare Choice + Rx (HMO-POS).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Providence Medicare Choice + Rx (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

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

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

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

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

SECTION 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIBA in Oregon at 1-800-722-4134 (TTY 711). You can call SHIBA in Washington at 1-800-562-6900 (TTY 360-586-0241). You can learn more about SHIBA by visiting their website (www.shiba.oregon.gov or www.insurance.wa.gov/shiba).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help.

- **"Extra Help" from Medicare**. People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through CAREAssist in Oregon or Early Intervention Program (EIP) in Washington. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call CAREAssist at 971-673-0144 or 1-800-805-2313 (TTY 711), or the Early Intervention Program (EIP) at 1-877-376-9316. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 855-742-2779 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Providence Medicare Choice + Rx (HMO-POS)

Questions? We're here to help. Please call Customer Service at 503-574-8000 or 1-800-603-2340. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m. (Pacific Time), seven days a week. Calls to these numbers are free.

Read your 2025 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the 2025 *Evidence of Coverage* for Providence Medicare Choice + Rx (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.ProvidenceHealthAssurance.com/EOC. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

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

Providence
Medicare Advantage Plans

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-603-2340 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-603-2340 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Providence
Medicare Advantage Plans

Form Approved
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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على1-800-603-2340 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-603-2340 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-603-2340 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。