

## ***Providence Medicare Extra + Rx (HMO) offered by Providence Health Assurance***

# **Annual Notice of Change for 2026**

You're enrolled as a member of Providence Medicare Extra + Rx (HMO).

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 Providence Medicare Extra + Rx (HMO).
- 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 [www.ProvidenceHealthAssurance.com/EOC](http://www.ProvidenceHealthAssurance.com/EOC) or call Customer Service at 503-574-8000 or 1-800-603-2340 (TTY users call 711) to get a copy by mail.

### **More Resources**

- Call Customer Service at 503-574-8000 or 1-800-603-2340 (TTY users call 711) for more information. From April 1st to September 30th, the hours are Monday through Friday from 8 a.m. to 8 p.m. From October 1st to March 31st, the hours are Sunday through Saturday (7 days a week) from 8 a.m. to 8 p.m. This call is free.
- This information is available in multiple formats, including large print and braille.

### **About Providence Medicare Extra + Rx (HMO)**

- 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 material says “we,” “us,” or “our,” it means Providence Health Assurance. When it says “plan” or “our plan,” it means Providence Medicare Extra + Rx (HMO).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Providence Medicare Extra + Rx (HMO).** Starting January 1, 2026, you'll get your medical and drug coverage through Providence Medicare Extra + Rx (HMO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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## Summary of Important Costs for 2026

|                                                                                                                                                                                                                                                                                                                                      | 2025<br>(this year)                                                                                                                                            | 2026<br>(next year)                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>* Your premium can be higher than this amount. Go to Section 1.1 for details.                                                                                                                                                                                                                        | \$161                                                                                                                                                          | \$161                                                                                                                                                                 |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you'll pay out of pocket for covered services.<br>(Go to Section 1.2 for details.)                                                                                                                                                                                    | \$4,000                                                                                                                                                        | \$4,200                                                                                                                                                               |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                                                                                    | \$0 per visit                                                                                                                                                  | \$0 per visit                                                                                                                                                         |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                                                                                      | \$20 per visit                                                                                                                                                 | \$20 per visit                                                                                                                                                        |
| <b>Inpatient hospital stays</b><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. | \$250 copayment each day for days 1-5 and there is no coinsurance, copayment, or deductible for day 6 and beyond for Medicare-covered inpatient hospital care. | <b>\$250 copayment each day for days 1-5 and there is no coinsurance, copayment, or deductible for day 6 and beyond for Medicare-covered inpatient hospital care.</b> |

|                                                                                                                                                  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part D drug coverage deductible</b><br>(Go to Section 1.7 for details.)                                                                       | Deductible: \$0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Deductible: \$0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | Copayment/Coinsurance during the Initial Coverage Stage: <ul style="list-style-type: none"> <li>• Drug Tier 1: \$0 per month supply at a preferred network pharmacy or \$12 per month supply at a network pharmacy.</li> <li>• Drug Tier 2: \$10 per month supply at a preferred network pharmacy or \$20 per month supply at a network pharmacy.</li> <li>• Drug Tier 3: \$40 per month supply at a preferred network pharmacy or \$47 per month supply at a network pharmacy.</li> </ul> You pay \$35 per month supply of each covered insulin product on this tier. | <b>Copayment/Coinsurance during the Initial Coverage Stage:</b> <ul style="list-style-type: none"> <li>• <b>Drug Tier 1: \$0 per month supply at a preferred network pharmacy or \$12 per month supply at a network pharmacy.</b></li> <li>• <b>Drug Tier 2: \$10 per month supply at a preferred network pharmacy or \$20 per month supply at a network pharmacy.</b></li> <li>• <b>Drug Tier 3: \$40 per month supply at a preferred network pharmacy or \$47 per month supply at a network pharmacy.</b></li> </ul> <b>You pay \$35 per month supply of each covered insulin product on this tier.</b> |

|  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <ul style="list-style-type: none"><li>• Drug Tier 4: \$90 per month supply at a preferred network pharmacy or \$100 per month supply at a network pharmacy.<br/><br/>You pay \$35 per month supply of each covered insulin product on this tier.</li><li>• Drug Tier 5: 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a network pharmacy.</li></ul> <p>Catastrophic Coverage Stage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs.</p> | <ul style="list-style-type: none"><li>• <b>Drug Tier 4: \$90 per month supply at a preferred network pharmacy or \$100 per month supply at a network pharmacy.</b><br/><br/><b>You pay \$35 per month supply of each covered insulin product on this tier.</b></li><li>• <b>Drug Tier 5: 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a network pharmacy.</b></li></ul> <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.)                                                                                                                                                                            | \$161                                                                       | <b>\$161</b><br>There is no change for the upcoming benefit year.                                           |
| <b>Additional premium for optional supplemental benefits</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.) | Providence Dental Basic<br>\$37.50<br>Providence Dental Enhanced<br>\$53.50 | <b>Providence Dental Basic<br/>           \$39</b><br><b>Providence Dental Enhanced<br/>           \$56</b> |

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

- **Late Enrollment Penalty** - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- **Higher Income Surcharge** - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- **Extra Help** - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 1 for more information about Extra Help from Medicare.

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

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered services 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.<br>Our plan premium and your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount. | \$4,000             | <b>\$4,200</b><br><b>Once you've paid \$4,200 out of pocket for covered services, you'll pay nothing for your covered services for the rest of the calendar year.</b> |

## Section 1.3 Changes to the Provider Network

There are no changes to our network of providers for next year.

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 Customer Service at 503-574-8000 or 1-800-603-2340 (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.

There are no changes to our network of pharmacies for next year.

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 Customer Service at 503-574-8000 or 1-800-603-2340 (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>Emergency care</b>                                         | \$125                                                                                                                | <b>\$130</b>                                                                                                                          |
| <b>Hearing aids</b>                                           | \$699 copayment per Advanced hearing aid or \$999 copayment per Premium hearing aid                                  | <b>\$499 copayment per Standard hearing aid, \$699 copayment per Advanced hearing aid, or \$999 copayment per Premium hearing aid</b> |
| <b>Medicare-covered chiropractic services and acupuncture</b> | Prior authorization not required                                                                                     | <b>Prior authorization may be required</b>                                                                                            |
| <b>Non-emergency medical transportation</b>                   | Covered                                                                                                              | <b>Not Covered</b>                                                                                                                    |
| <b>Outpatient Rehabilitation Services</b>                     | Prior authorization is not required for initial rehab services; however, subsequent visits may require authorization | <b>Prior authorization may be required for initial rehab services and subsequent visits</b>                                           |
| <b>Over-the-counter (OTC) items</b>                           | \$160 allowance every three months                                                                                   | <b>\$240 allowance every six months</b>                                                                                               |



|                                             | 2025<br>(this year)                                                                            | 2026<br>(next year)                                                                                   |
|---------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>Routine eyeglasses or contact lenses</b> | Allowance of up to \$250 per calendar year for any combination of routine prescription eyewear | <b>Allowance of up to \$150 per calendar year for any combination of routine prescription eyewear</b> |
| <b>Skilled nursing facility (SNF)</b>       | \$214 per day for days 21-100                                                                  | <b>\$218 per day for days 21-100</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.

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 Customer Service at 503-574-8000 or 1-800-603-2340 (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 may not apply to you.** We have included 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 didn't get this material with this packet, call Customer Service at 503-574-8000 or 1-800-603-2340 (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.

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):</b> | Standard cost sharing:<br>You pay \$12 per prescription.<br><br>Preferred cost sharing:<br>You pay \$0 per prescription.  | <b>Standard cost sharing:</b><br><b>You pay \$12 per prescription.</b><br><br><b>Preferred cost sharing:</b><br><b>You pay \$0 per prescription.</b>  |
| <b>Tier 2 (Generic):</b>           | Standard cost sharing:<br>You pay \$20 per prescription.<br><br>Preferred cost sharing:<br>You pay \$10 per prescription. | <b>Standard cost sharing:</b><br><b>You pay \$20 per prescription.</b><br><br><b>Preferred cost sharing:</b><br><b>You pay \$10 per prescription.</b> |

|                                      | 2025<br>(this year)                                                                                                                                                                                  | 2026<br>(next year)                                                                                                                                                                                                       |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                      | Your cost for a one-month mail-order prescription is \$0                                                                                                                                             | <b>Your cost for a one-month mail-order prescription is \$0</b>                                                                                                                                                           |
| <b>Tier 3 (Preferred Brand):</b>     | <p>Standard cost sharing:<br/>You pay \$47 per prescription.</p> <p>Preferred cost sharing:<br/>You pay \$40 per prescription.</p> <p>Your cost for a one-month mail-order prescription is \$40.</p> | <p><b>Standard cost sharing:<br/>You pay \$47 per prescription.</b></p> <p><b>Preferred cost sharing:<br/>You pay \$40 per prescription.</b></p> <p><b>Your cost for a one-month mail-order prescription is \$40.</b></p> |
| <b>Tier 4 (Non-Preferred Drugs):</b> | <p>Standard cost sharing:<br/>You pay \$100 per prescription.</p> <p>Preferred cost sharing:<br/>You pay \$90 per prescription.</p>                                                                  | <p><b>Standard cost sharing:<br/>You pay \$100 per prescription.</b></p> <p><b>Preferred cost sharing:<br/>You pay \$90 per prescription.</b></p>                                                                         |
| <b>Tier 5 (Specialty):</b>           | <p>Standard cost sharing:<br/>You pay 33% per prescription.</p> <p>Preferred cost sharing:<br/>You pay 33% per prescription.</p>                                                                     | <p><b>Standard cost sharing:<br/>You pay 33% per prescription.</b></p> <p><b>Preferred cost sharing:<br/>You pay 33% per prescription.</b></p>                                                                            |

### 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**

|                                                                                    | <b>2025<br/>(this year)</b>                                                                                                                                                                                                                                                                  | <b>2026<br/>(next year)</b>                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Customer Service hours</b>                                                      | Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.                                                                                                                                                                                                                                | <b>From April 1st to September 30th, the hours are Monday through Friday from 8 a.m. to 8 p.m. From October 1st to March 31st, the hours are Sunday through Saturday (7 days a week) from 8 a.m. to 8 p.m.</b>                                                                                                                                    |
| <b>Diabetic Testing Supplies (meters and strips) obtained through the pharmacy</b> | Preferred products are Roche branded products (Accu-Chek) and Lifescan branded products (OneTouch).                                                                                                                                                                                          | <b>Preferred products are Roche branded products (Accu-Chek) and Abbott branded products (Freestyle).</b>                                                                                                                                                                                                                                         |
| <b>Medicare Prescription Payment Plan</b>                                          | <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).</p> <p>You may be participating in this payment option.</p> | <p><b>If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.</b></p> <p><b>To learn more about this payment option, call us at 855-742-2779 (TTY users call 711) or visit <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</b></p> |

|                                                             | <b>2025<br/>(this year)</b>                                                                                                                                                                                                       | <b>2026<br/>(next year)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Optional Supplemental Benefit Enrollment Time Frames</b> | If you are currently a member of Providence Medicare Advantage Plans, you may change or elect your Optional Supplemental Dental Plan during the Annual Enrollment Period (AEP) or within the first 60 days following January 1st. | <b>If you are currently a member of Providence Medicare Advantage Plans, you may change or elect your Optional Supplemental Dental Plan during the Open Enrollment Period (OEP), through the end of December, or within the first 60 days following January 1st. If you had a recent plan change outside of the time frame described above, you will have an additional 60 days from your new effective date of coverage to change or elect your Optional Supplemental Dental Plan.</b> |

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## SECTION 3 How to Change Plans

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**To stay in Providence Medicare Extra + Rx (HMO), 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 Providence Medicare Extra + Rx (HMO).

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 Providence Medicare Extra + Rx (HMO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Providence Medicare Extra + Rx (HMO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at 503-574-8000 or 1-800-603-2340 (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, Providence Health Assurance 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.

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#### **SECTION 4    Get Help Paying for Prescription Drugs**

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

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the California AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-916-449-5900. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the



calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-855-742-2779 or visit [www.Medicare.gov](http://www.Medicare.gov).

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## SECTION 5 Questions?

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### Get Help from Providence Medicare Extra + Rx (HMO)

- **Call Customer Service at 503-574-8000 or 1-800-603-2340 (TTY users call 711).**

We're available for phone calls. From April 1st to September 30th, the hours are Monday through Friday from 8 a.m. to 8 p.m. From October 1st to March 31st, the hours are Sunday through Saturday (7 days a week) from 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, look in the 2026 *Evidence of Coverage* for Providence Medicare Extra + Rx (HMO). 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 [www.ProvidenceHealthAssurance.com/EOC](http://www.ProvidenceHealthAssurance.com/EOC) or call Customer Service at 503-574-8000 or 1-800-603-2340 (TTY users call 711) to ask us to mail you a copy.

- **Visit [www.ProvidenceHealthAssurance.com/findaprovider](http://www.ProvidenceHealthAssurance.com/findaprovider)**

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 Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA). In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (also SHIBA).

Call SHIBA to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. 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). Learn more about SHIBA by visiting [www.shiba.oregon.gov](http://www.shiba.oregon.gov) or [www.insurance.wa.gov/shiba](http://www.insurance.wa.gov/shiba).

### Get Help from Medicare

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

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

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

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

- **Write to Medicare**

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

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

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

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

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

## **Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**

### **English**

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-603-2340 (TTY: 711) or speak to your provider."

### **Español (Spanish)**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-603-2340 (TTY: 711) o hable con su proveedor.

### **Việt (Vietnamese)**

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-603-2340 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

### **中文 (Chinese-Simplified)**

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-603-2340（文本电话：711）或咨询您的服务提供商。"

### **中文 (Chinese- Traditional)**

注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-603-2340（TTY：711）或與您的提供者討論。」

### **РУССКИЙ (Russian)**

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-603-2340 (TTY: 711) или обратитесь к своему поставщику услуг.

## 한국어 (Korean)

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-603-2340 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오."

## українська мова (Ukrainian)

УВАГА: Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-603-2340 (TTY: 711) або зверніться до свого постачальника».

## 日本語 (Japanese)

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-603-2340 (TTY: 711)までお電話ください。または、ご利用の事業者にご相談ください。

## العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-603-2340 (711) أو تحدث إلى مقدم الخدمة".

## ភាសាខ្មែរ (Khmer)

សូមយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសា ឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបាន ដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-603-2340 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។"

## Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-603-2340 (TTY: 711) an oder sprechen Sie mit Ihrem Provider."

## فارسي (Farsi)

توجه: اگر فارسي صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-800-603-2340 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

## Français (French)

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-603-2340 (TTY : 711) ou parlez à votre fournisseur. »

## ไทย (Thai)

หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-603-2340 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ”

## Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-603-2340 (TTY: 711) o makipag-usap sa iyong provider.”

## አማርኛ (Amharic)

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆኑ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-603-2340 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።”

## ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।”

## ລາວ (Laos)

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-603-2340 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ."

## ՀԱՅԵՐԵՆ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվակալան անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրվում է համապատասխան օժանդակ միջոցներով ծառայությունները նույնպես տրամադրվում են անվճար: Չանգահարեք 1-800-603-2340 հեռախոսահամարով (TTY` 711) կամ խոսեք Ձեր մատակարարի հետ:

## Lus Hmoob (Hmong)

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-603-2340 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob."

## हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-603-2340 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।"