Dear Member:

Thank you for your continued membership in Kaiser Permanente Medicare Advantage (HMO).

We are providing important information about your Medicare health care and prescription drug coverage effective January 1, 2022. Included are the following documents with important information for you.

1. Please start by reading the **Annual Notice of Changes and Evidence of Coverage Amendment for 2022**. It gives you a summary of changes we are making to your benefits and costs effective January 1, 2022. This notice only describes changes that our plan is making (or as required by Medicare for Part D plans).
   - Please review this notice within a few days of receiving it to see how the changes might affect you. It also amends your current **Evidence of Coverage**, effective January 1, 2022. We will send you a notice once the **Evidence of Coverage** for your group's 2022 contract period is posted online shortly after your group renews its contract in 2022. Please be aware that your group can make changes upon renewal or at other times during its contract period. If you have questions about the benefits your group will offer during its 2022 contract period, please contact your group's benefits administrator.
   - If you decide to stay with our plan, you do not have to fill out any paperwork unless you are instructed otherwise by your group. You will automatically stay enrolled as a member of our plan.
   - If you decide to leave our plan, you should check with your group's benefits administrator before you switch to a different plan. Your group determines eligibility for enrollment under its group plan, including the available plans, if any, and the times when you can switch to a different plan offered by your group. Please contact your group's benefits administrator for details.

2. A notice called **Additional plan information** explains how to get information about provider locations or our formulary, request a print copy of our **Comprehensive Formulary** or **Provider Directory**, or view them online.

If you have questions, we're here to help. Please call Member Services toll free at **1-888-901-4600** (TTY users call **711**). Hours are seven days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers. You can also visit our website at [kp.org/wa](http://kp.org/wa).

We value your membership and hope to continue to serve you next year.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
2022 Annual Notice of Changes and Evidence of Coverage Amendment for Group Members

You are currently enrolled as a member of Kaiser Permanente Medicare Advantage. Next year, there will be some changes to our plan's costs and benefits. This booklet tells about some of the changes effective January 1, 2022, unless otherwise noted. It also amends your current Evidence of Coverage.

2022 changes

We're sending you this Annual Notice of Changes and Evidence of Coverage Amendment to tell you about the changes our plan is making effective January 1, 2022 (unless otherwise noted), for all Kaiser Permanente Medicare Advantage group members, in accord with the Centers for Medicare & Medicaid Services (CMS) requirements. This notice only describes changes required by our plan (or Medicare for Part D prescription drug plans). This notice doesn't describe any other changes; for example, changes made at the request of a group. Please contact your group's benefits administrator for more information.

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.
     - It's important to review your coverage now to make sure it will meet your needs next year.
     - Do the changes affect the services you use?
     - Look in Section 1 for information about benefit and cost changes for our plan.
   - Check the changes in the booklet to our prescription drug coverage to see if they affect you.
♦ Will your drugs be covered?
♦ Are your drugs in a different tier, with different cost-sharing?
♦ Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
♦ Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
♦ Look in Section 1.6 for information about changes to our drug coverage.
♦ Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit go.medicare.gov/drugprices, and click the “dashboards” link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.
♦ Are your doctors, including specialists you see regularly, in our network?
♦ What about the hospitals or other providers you use?
♦ Look in Section 1.3 for information about our Provider Directory.

If you decide to change plans in 2022:

- Your group determines eligibility for enrollment under its group plan, including the plans that are available through your group and the times when you can switch to another plan offered by your group.
- You must check with your group's benefits administrator before you change your plan. This is important because you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans.

Additional resources

- Please contact our Member Services number at 1-888-901-4600 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week.
- This document is available in braille or large print if you need it by calling Member Services.
- Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.
About Kaiser Permanente Medicare Advantage

- Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

- When this Annual Notice of Changes and Evidence of Coverage Amendment says "we," "us," or "our," it means Kaiser Foundation Health Plan of Washington (Health Plan). When it says "plan" or "our plan," it means Kaiser Permanente Medicare Advantage.
Annual Notice of Changes and Amendment

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Section 1 — Changes to benefits and costs for next year

Section 1.1 – Changes to the monthly premium

Your group will notify you about any change in your group's premium if the change affects the amount you will be expected to pay. If you have any questions about your contribution toward your group's premium, please contact your group's benefits administrator. You must continue to pay your Medicare premiums, and 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 contribution to your group's premium may 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 enroll in Medicare prescription drug coverage in the future.

- Your contribution to your group's premium may be less if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to your maximum out-of-pocket amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services (and other health care services not covered by Medicare as described in Chapter 4 of the Evidence of Coverage) for the rest of the year.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum out-of-pocket amount</strong>&lt;br&gt;Your costs for covered medical services (and certain health care services not covered by Medicare) (such as copayments) count toward your maximum out-of-pocket amount. Your contribution toward your group's premium and costs for Medicare Part D prescription drugs does not count toward your maximum out-of-pocket amount.</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

Once you have paid the maximum out-of-pocket amount for covered Part A and Part B services (and certain health care services not covered by Medicare), you will pay nothing for these covered services for the rest of the calendar year.
Section 1.3 – Changes to the provider network

There are changes to our network of providers for next year. Early in October 2021, we will post our 2022 Provider Directory on our website at wa-medicare.kp.org/providers. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. Please review our 2022 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the pharmacy network

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.

There are changes to our network of pharmacies for next year. Early in October 2021, we will post our 2022 Pharmacy Directory on our website at wa-medicare.kp.org/providers. You may also call Member Services for updated pharmacy information or to ask us to mail you a Pharmacy Directory. Please review our 2022 Pharmacy Directory to see which pharmacies are in our network.

Section 1.5 – Changes to benefits and costs for medical services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," in your 2022 Evidence of Coverage.
<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness benefit (the Silver&amp;Fit® Healthy Aging and Exercise Program)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Silver&amp;Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&amp;Fit is a federally registered trademark of ASH and used with permission herein.</td>
<td>You can choose one of the following:</td>
<td>You receive the following:</td>
</tr>
<tr>
<td></td>
<td>• A standard gym membership.</td>
<td>• A standard gym membership.</td>
</tr>
<tr>
<td></td>
<td>• Two home fitness kits from a variety of kits.</td>
<td>• A home fitness kit to exercise at home (you can also choose a kit that includes an activity tracker).</td>
</tr>
</tbody>
</table>

**Section 1.6 – Changes to Part D prescription drug coverage**

**Changes to our Drug List**

Our list of covered drugs is called a formulary, or Drug List. A copy of our Drug List is provided electronically at kp.org/wa/medicare/formulary.

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. Drugs that are covered for only select medical conditions will be identified on our Drug List and in Medicare Plan Finder, along with the specific medical conditions that they cover.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug. We encourage current members to ask for an exception before next year.
- To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage*, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)" or call Member Services.
- Work with your doctor (or other prescriber) to find a different drug that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary

1-888-901-4600 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

**Note:** Certain drugs have been removed from our 2022 Drug List. If your drug has been removed from our Drug List, you can discuss with your physician if there are other drugs on our Drug List that will work for you. If your physician determines that the other drugs will not work for you, you or your physician can request that we make a formulary exception. If we approve your request for brand-name drugs, you will pay the cost-sharing applicable to Tier 4 drugs (nonpreferred brand-name), or for generic drugs, you will pay the cost-sharing applicable to Tier 2 drugs (generic). In addition, if we approved a formulary exception for you during 2021, you or your physician will need to ask us for a formulary exception for 2022.

Most of the changes in our Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to our Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to our Drug List, see Chapter 5, Section 6, of the Evidence of Coverage.

**Changes to prescription drug costs**

**Note:** If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs does not apply to you. We sent you a separate document, 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 haven't received this rider by September 30, 2021, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2, of your Evidence of Coverage for more information about the stages.)

The information below shows the changes for next year to the first two stages—the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages—the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at <Chapter 6, Sections 6 and 7, in the Evidence of Coverage.

**Changes to the Deductible Stage**

<table>
<thead>
<tr>
<th>Stage</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Yearly Deductible Stage</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
</tbody>
</table>

1-888-901-4600 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
Changes to your cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, "Types of out-of-pocket costs you may pay for covered drugs," in your Evidence of Coverage.

<table>
<thead>
<tr>
<th>Stage</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2: Initial Coverage Stage</td>
<td>Once you have paid $6,550 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</td>
<td>Once you have paid $7,050 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</td>
</tr>
</tbody>
</table>

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.

Changes to the Catastrophic Coverage Stage

The other drug coverage stage—the Catastrophic Coverage Stage—is for people with high drug costs. Most members do not reach the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.

Section 2 — Administrative changes

<table>
<thead>
<tr>
<th>Description</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term of Evidence of Coverage</td>
<td>The term of your current Evidence of Coverage is revised to be in effect for the months in which you are enrolled in Kaiser Permanente Medicare Advantage between January 1, 2021, and December 31, 2021, unless amended. If your group's Agreement renews at a later date in 2021, the term of your current Evidence of Coverage is revised to be in effect for the months in which you are enrolled in Kaiser Permanente Medicare Advantage during.</td>
<td>The term of your current Evidence of Coverage is revised to be in effect for the months in which you are enrolled in Kaiser Permanente Medicare Advantage between January 1, 2022, and December 31, 2022, unless amended. If your group's Agreement renews at a later date in 2022, the term of your current Evidence of Coverage is revised to be in effect for the months in which you are enrolled in Kaiser Permanente Medicare Advantage during.</td>
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</tbody>
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1-888-901-4600 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
<table>
<thead>
<tr>
<th>Description</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>that contract period, unless amended.</td>
<td>Medicare Advantage during that contract period, unless amended.</td>
</tr>
</tbody>
</table>

```markdown
Section 3 — Deciding which plan to choose

**Section 3.1 – If you want to stay in our plan**

Your group determines eligibility for enrollment under its group plan, including the plans that are available through your group and the times when you can switch to another plan offered by your group.

**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, you must check with your group’s benefits administrator before you change your plan. This is important because you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans.

```markdown
Section 4 — Programs that offer free counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA). SHIBA is independent (not connected with any insurance company or health plan). 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 at **1-800-562-6900** (TTY users should call **1-360-586-0241**). You can learn more about SHIBA by visiting their website [https://www.insurance.wa.gov/shiba](https://www.insurance.wa.gov/shiba).

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Section 5 — 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, annual deductibles, and

1-888-901-4600 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. 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 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
- Your state Medicaid office (applications).

- **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. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the **Washington Early Intervention Program.** For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Early Intervention Program at **1-877-376-9316**.

### Section 6 — Questions?

#### Section 6.1 – Getting help from our plan

Questions? We're here to help. Please call Member Services at **1-888-901-4600**. (TTY only, call 711.) We are available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

**Read your 2022 Evidence of Coverage (it has details about benefits and costs)**

This Annual Notice of Changes and Evidence of Coverage Amendment gives you a summary of some changes in your benefits and costs for 2022 that our plan is making and it amends your current Evidence of Coverage. We will send you a notice once the Evidence of Coverage for your group's 2022 contract period is posted online shortly after your group renews its contract in 2022. Please keep in mind that groups can make changes to your group plan at any time.

**Visit our website**

You can also visit our website at kp.org/wa. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Kaiser Permanente 2022 Comprehensive Formulary).

#### Section 6.2 – 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**.

  **1-888-901-4600** (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
- **Visit the Medicare website**
  - You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to [www.medicare.gov/plan-compare](http://www.medicare.gov/plan-compare)).

- **Read Medicare & You 2022**
  - You can read the *Medicare & You* 2022 handbook. Every year in the fall, this booklet 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 booklet, you can get it at the Medicare website ([www.medicare.gov](http://www.medicare.gov)) 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**.

1-888-901-4600 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
# Kaiser Permanente Medicare Advantage Member Services

<table>
<thead>
<tr>
<th>METHOD</th>
<th>Member Services – contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-901-4600</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.</td>
</tr>
<tr>
<td></td>
<td>Member Services also has free language interpreter services available for non-English speakers.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.</td>
</tr>
<tr>
<td>WRITE</td>
<td>Kaiser Foundation Health Plan of Washington</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 9010</td>
</tr>
<tr>
<td></td>
<td>Renton, WA 98057-9010</td>
</tr>
<tr>
<td></td>
<td>RCR-A1N-08, Member Services</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>kp.org/wa</td>
</tr>
</tbody>
</table>
KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

Kaiser Permanente
Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Electronically: kp.org/wa/feedback

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, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.
LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).


中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-901-4636 (TTY: 1-800-833-6388 / 711)。


Türkçe (Turkish): DUMİLE: İngilizce konuşmayanlarınız için derhal ücretsiz dengeli hizmetler sağlanmaktadır. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) ile konuşun.

العربية (Arabic): لديكم حقوق الوصول على مساعدة ومعنويات متوفرة للجميع، إذا كنت تتحدث لغة أخرى، فإن خدمات المساعدة اللغوية تتوفر لك بال($) 1-888-901-4636 (TTY: 1-800-833-6388 / 711).


ਪੰਜਾਬੀ (Punjabi): ਪਹਿਚਾਣ: ਜੋ ਨੋਟ ਪੰਜਾਬੀ ਅਨਦ਼ਾਨੀ, ਤੌਂ ਜੋ ਹੋ ਚੌੜਾ ਦੀ ਤਰਜਮਾਨੀ ਕਰਨ ਦੀ ਸਹੱਸਰਤਾ ਹੈ, ਤੋਂ ਦਿੱਤੀ ਜਾਣ ਦਿੱਤੀ ਪੰਜਾਬੀ ਸ਼ੁਧ ਸ਼ਿਕਾਰ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) ਦੀ ਸੜਕ ਬਾਣੀ।


فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می شود (TTY: 1-888-901-4636 / 711)
Plan information

Provider directories

If you need help finding a network provider or pharmacy, please visit kp.org/wa/medicare/providers to search our online directory (Note: the 2022 directories are available online starting 10/15/2021 in accord with Medicare requirements).

To get a Provider Directory or Pharmacy Directory (if applicable), mailed to you, you can call Kaiser Permanente Member Services at 1-888-901-4600 (TTY 711), 8 a.m. to 8 p.m., 7 days a week.

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 (Note: the 2022 formulary is available online starting 10/15/2021 in accord with Medicare requirements) at kp.org/wa/medicare/formulary.

To get a formulary mailed to you, you can call Kaiser Permanente at 1-888-901-4600 (TTY 711), 8 a.m. to 8 p.m., 7 days a week.

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 kpwa.memberdoc.com to view your EOC online (Note: the 2022 EOC for Washington is available online starting 12/31/2021 in accord with Medicare requirements).

To get an EOC mailed to you, you can call Kaiser Permanente at 1-888-901-4600 (TTY 711), 8 a.m. to 8 p.m., 7 days a week.