2023

Being an informed Kaiser Permanente member

KAISER PERMANENTE®

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Table of contents

Contact us

Member Services

If you need assistance with or have questions about your health plan or specific benefits, you can speak with one of our Member Services representatives at **1-888-777-5536** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

Appointments and 24-hour medical advice

You can call to make appointments 24 hours a day, 7 days a week. Medical advice is also available 24 hours a day, 7 days a week. For either of these services, call:

- Within the Washington, DC, metro area, **1-703-359-7878** (TTY **711**).
- Outside the Washington, DC, metro area, **1-800-777-7904** (TTY **711**).

If your doctor is in the community, call his or her office directly. If you would like to leave a nonurgent message for a medical advice nurse, registered users can do so at **kp.org**; you will receive an answer within one business day.

Prescription refills

After registering on **kp.org**, you can also manage your prescriptions online by signing in to **kp.org/pharmacy** or the Kaiser Permanente app. Available 24 hours a day by calling **1-800-700-1479.**

How to access a list of providers

To access our online provider directory, visit **kp.org/directory**. To request a copy of the provider directory, please call Member Services.

Get Care – Virtual Care—Covid—MAS

As a Kaiser Permanente member, we are standing with you during extraordinary times. While the coronavirus affects lives across the country, we're here to help keep you and your loved ones safe and healthy. Your Kaiser Permanente doctor, specialists, and health plan are all part of one connected team—coordinating your care seamlessly so you don't have to and providing you access to care from the comfort and safety of your own home. Let's review how your health plan will support you.

You can't always plan on when you'll need care. That's why Kaiser Permanente offers many convenient ways to get you the care you need, on your time, where you are for low to no cost.

Whether you're at home, at work, or on the go, you've got options for connecting with your care team.

We'd like to share with you all the ways you can connect with your Kaiser Permanente care team and access quality care.

- Be sure to register on **kp.org** and download the Kaiser Permanente app to get care advice, find treatment plans, and more.
- Plus, you can also email your doctor's office with nonurgent health questions anytime.
- Can't make it to the doctor's office?
  - Try a phone appointment or a video visit for the same quality care as an in-person appointment.
  - Both options are great for minor health conditions and can be scheduled on our app, online, or over the phone.

Not sure which kind of care is right for you? Advice is available 24/7. Just visit **kp.org/getcare** or call us to talk to a licensed care provider anytime.

The next time you need care, we're here to help you thrive—your way.

That means getting the care you need, when you need it. Thanks for choosing Kaiser Permanente as your partner in health. Download the app now so you're ready the next time you need care.

Member rights and responsibilities: Our commitment to each other

Kaiser Permanente is committed to providing you and your family with quality health care services. In a spirit of partnership with you, here are the rights and responsibilities we share in the delivery of your health care services.

Member rights: We must honor your rights as a member of our plan

1. **We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, large print or braille)**

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English-speaking members. We can also give you information in large print or braille at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our network for a specialty are not available, it is our responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our network that cover a service you need, call us for information on where to go to obtain this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services. You may also file a complaint with Medicare by calling **1-800-MEDICARE** (**1-800-633-4227**) or directly with the Office for Civil Rights **1-800-368-1019** or TTY **1-800-537-7697**.

2. **We must ensure that you get timely access to your covered services and drugs**

You have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral, as well as other providers described in your *Evidence of Coverage*.

You have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, your *Evidence of Coverage* tells you what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, your *Evidence of Coverage* tells you what you can do.) To receive a copy of your *Evidence of Coverage*, call Member Services.

3. We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in our plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you or someone you have given legal power to make decisions for you first.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

4. We must give you information about our plan, our network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in number 1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish, braille, or large print.)

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers, and pharmacies.**
  - You have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in our network, visit **kp.org/directory**.
  - For a list of the pharmacies in our network, visit **kp.org/directory**.
  - For more detailed information about our providers or pharmacies, you can call Member Services or visit our website at **kp.org/directory**.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In your *Evidence of Coverage*, we explain what medical services and Part D prescription drugs are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Member Services.
- **Information about why something is not covered and what you can do about it.**
  - Your *Evidence of Coverage* provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Your *Evidence of Coverage* also provides information on asking us to change a decision, also called an appeal.

5. You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with:

District of Columbia residents

District of Columbia Department of Insurance, Securities and Banking
810 First St. NE, Suite 701
Washington, DC 20002

Maryland residents

Maryland Insurance Administration
Consumer Complaint Investigation
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Virginia residents

State Corporation Commission Virginia Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

6. You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, your *Evidence of Coverage* tells you what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

7. What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697,** or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, see your *Evidence of Coverage*.
- Or you can call Medicare at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048.**

8. How to get more information about your rights

There are several places where you can get more information about your rights:

- **You can call Member Services.**
- **You can call the SHIP.** For details about this organization and how to contact it, see your *Evidence of Coverage*.
- **You can contact Medicare:**
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
  - Or 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.**

9. Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

10. You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this booklet. Please call Member Services with any suggestions.

Member responsibilities: You have some responsibilities as a member of our plan

What are your responsibilities?

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use your *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Your *Evidence of Coverage* gives details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Your *Evidence of Coverage* gives details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know.
  - Your *Evidence of Coverage* tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health care providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay a premium for your Medicare Part B to remain a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of our plan.
- **If you move within your plan's service area,** we need to know so we can keep your membership record up-to-date and know how to contact you.
- **If you move outside of your plan's service area,** you cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

Method	Member Services – contact information
Call	**1-888-777-5536**
	Calls to this number are free, 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711**
	Calls to this number are free, 7 days a week, 8 a.m. to 8 p.m.
Fax	**1-866-640-9826**
Write	Kaiser Permanente Member Services 2101 E. Jefferson St. Rockville, MD 20852
Website	**kp.org**

Member compliment and complaint procedures

You have the right to file a compliment or complaint with Kaiser Permanente. We encourage you to let us know about the excellent care you have received as a member of Kaiser Permanente or about any concerns or problems you have experienced.

Member Services representatives are dedicated to answering questions about your health plan benefits, available services, and the facilities where you can receive care. For example, they can explain how to make your first medical appointment, what to do if you move or need care while you are traveling, or how to replace an ID card. They can also help you file a claim for emergency services and urgent care services, both in and outside of our service area, or file an appeal.

Member assistance and resource specialists are available at most Kaiser Permanente medical center administration offices, or you can call Member Services.

Written compliments or complaints should be sent to:

Kaiser Permanente Member Services
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736
Fax: **404-949-5001**

A Member Services representative will coordinate with the appropriate departments to investigate and resolve your complaint. If your complaint involves the health plan's decision not to authorize medical services or drugs, or not to pay a claim, you have the right to file an appeal.

Medically urgent situations

How to file an urgent appeal

Expedited appeals are available for medically urgent situations. In these cases, call Member Services.

After business hours, call an advice nurse

- within the Washington, DC metro area, **1-703-359-7878** (TTY **711**) or
- outside the Washington, DC metro area, toll free at **1-800-777-7904** (TTY **711**).

How to file a nonurgent appeal

Appeals for nonurgent services must be submitted in writing. When doing so, please include

- The member's name and medical record number
- A description of the service or claim that was denied
- Why you believe the Health Plan should authorize the service or pay the claim
- A copy of the denial notice you received

Send your appeal to:

Kaiser Permanente Member Services
Appeals Unit
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736
Fax: **404-949-5001**

Your request will be acknowledged by an appeals analyst who will inform you of any additional information that is needed and help you obtain information when necessary. The analyst will also conduct research and prepare your request for review by the appeals/grievances committee. Once the review is complete, you will receive a written notice of the health plan's decision regarding your appeal/grievance request. You will also receive information on any additional levels of review available to you. Detailed information on procedures for sharing compliments and complaints or for filing an appeal/grievance is provided in your *Evidence of Coverage*.

Right to independent review

We are committed to ensuring that your concerns are fairly and properly heard and resolved. After you have exhausted your complaint and appeal rights with Kaiser Permanente, if you continue to have concerns about your health care that you believe the Health Plan has not satisfactorily addressed, you have the right to request an independent review.

Additionally, under state or federal requirements, you may have the right to request a standard or expedited independent review before exhausting Kaiser Permanente's internal appeal process, or at the same time that your internal appeal is being processed, if:

- Health Plan fails to process your appeal within the required time frame.
- Health Plan does not share new or additional evidence considered, relied upon, or generated in connection with your appeal.
- Health Plan fails to provide new or additional rationale, prior to rendering a final decision.
- The adverse determination is related to cancer.
- You are receiving an ongoing course of treatment.
- The potential delay in receipt of a health care service until you exhaust the internal grievance or appeal process could result in (a) loss of life, (b) serious impairment to a bodily function, (c) serious dysfunction of a bodily organ, (d) continuing mental illness with symptoms that could cause danger to self or others, or (e) continuing experience of severe withdrawal symptoms.

You may request an independent review by contacting one of the following agencies. Please refer to your contract for specific details regarding your independent review rights and which agency you should contact.

IN MARYLAND

- **Office of the Attorney General**
  Consumer Protection Division
  Health Education and Advocacy Unit
  200 Saint Paul Place
  Baltimore, MD 21202
  877-261-8807 (toll-free)
  Web: www.marylandattorneygeneral.gov

- **Maryland Insurance Administration**
  Appeals and Grievance Unit
  200 Saint Paul Place, Suite 2700
  Baltimore, MD 21202
  410-468-2000
  800-492-6116 (toll-free)
  800-735-2258 (toll-free TTY)
  410-468-2270 or 410-468-2260 (fax)
  Web: www.mdinsurance.state.md.us

IN VIRGINIA

- **Office of the Managed Care Ombudsman**
  Virginia Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  877-310-6560 (toll-free)
  804-371-9032 (Richmond metropolitan area)
  804-371-9944 (fax)
  Web: scc.virginia.gov/pages/Office-of-the-Managed-Care-Ombudsman
  Email: ombudsman@scc.virginia.gov

- **State Corporation Commission**
  Bureau of Insurance, Life and Health Division
  P.O. Box 1157
  Richmond, VA 23218
  804-371-9691
  877-310-6560 (toll-free)
  804-371-9206 (TDD)
  Web: scc.virginia.gov/pages/Consumers

- **The Office of Licensure and Certification**
  Department of Health
  9960 Mayland Drive, Suite 401
  Richmond, VA 23233-1463
  804-367-2106
  800-955-1819 (toll-free)
  804-527-4503 (fax)
  Web: vdh.virginia.gov/licensure-and-certification
  Email: OLC-Complaints@vdh.virginia.gov

IN THE DISTRICT OF COLUMBIA

- **Office of Health Care Ombudsman and Bill of Rights**
  One Judiciary Square
  441 4th St. NW
  Suite 250 North
  Washington, DC 20001
  202-724-7491
  877-685-6391 (toll-free)
  202-442-6724 (fax)
  Web: www.healthcareombudsman.dc.gov
  Email: healthcareombudsman@dc.gov

FOR FEDERAL EMPLOYEES

- **United States Office of Personnel Management**
  Insurance Services Programs
  Health Insurance Group 3
  1900 E St. NW
  Washington, DC 20415-3630
  202-606-0755
  Web: www.opm.gov

How Kaiser Permanente physicians and health care professionals decide what to prescribe

When writing prescriptions for patients, most physicians and health care providers refer to a drug formulary, or list of covered drugs. The formulary is selected by our plan in consultation with a team of health care providers and represents drug therapies believed to be necessary for quality treatment.

Our drug formulary must meet requirements set by Medicare and is approved by Medicare. The presence of a drug on our formulary does not necessarily mean that your plan physician will prescribe it for your medical condition. Our drug formulary guidelines allow you to obtain Medicare Part D prescription drugs if a plan physician determines that they are medically necessary for your condition. If you disagree with your plan physician's decision on which drug to prescribe, you have the right to file an appeal with Kaiser Permanente. For information about the Kaiser Permanente appeals procedure, contact Member Services or refer to your *Evidence of Coverage*.

While most changes in drug coverage happen at the beginning of the year, there are some changes that may happen during the year. For example, we may, remove a drug from our formulary, replace a brand-name drug with a generic drug when a less expensive generic becomes available.

Usually these types of changes won't affect you until January 1 of the next year. But in some cases, you'll be affected by a change before January 1. If that happens, we'll either tell you 30 days before the change, or give you a 30-day supply when you ask for a refill at a Kaiser Permanente or affiliated pharmacy.

If the FDA decides a drug on our formulary isn't safe, or if the drug's manufacturer removes the drug from the market, we'll immediately remove the drug from our formulary and notify members who take the drug.

The cost sharing you pay for your drugs depends on your coverage stage and your drug's cost sharing tier on our formulary. The six drug cost-sharing tiers include preferred generic, generic, preferred brand name, non-preferred brand name, specialty drugs, and injectable Part D vaccines. Generic drugs have lower cost sharing than brand name or specialty drugs. Drugs in the preferred generic and preferred brand name tiers have lower cost sharing than drugs in the generic and non-preferred brand name tiers. Please refer to our Part D formulary for information about the cost-sharing tier for the drugs you take.

Note: If we approve your request for a tiering exception of a generic, preferred brand, or nonpreferred brand name drug, you will pay the cost sharing applicable to the preferred generic, generic, or preferred brand name drugs. Generally we will not approve your request for a tiering exception if a preferred generic or preferred brand name drug on our drug formulary would be just as effective as the generic or nonpreferred brand name drug.

Tiering exceptions cannot be made for preferred generic drugs or specialty drugs. For information regarding the Kaiser Permanente appeals procedure, contact Member Services or refer to your *Evidence of Coverage*. To learn more about the drug formulary, including how to request a tiering exception, please refer to the Abridged Formulary or visit **kp.org/seniorrx**. Check **kp.org** regularly for changes to the formulary. You can also request a copy of the formulary by calling Member Services.

Kaiser Permanente Medicare health plan drug benefits vary based upon the health benefit plan under which you are enrolled. Some, but not all, Kaiser Permanente Medicare health plans include coverage for Medicare Part D prescription drugs. Drug benefits may change from contract year to contract year. Please refer to your current *Evidence of Coverage* for your plan's prescription drug benefit.

Language services

As part of the Kaiser Permanente mission, we are committed to providing access to quality care and culturally competent service for all of our valued members—regardless of language preference, ability to hear, or cultural background. You have the right to no-cost language services for your health care needs. These services are available, so you can be confident that you will be understood whenever you call or visit a Kaiser Permanente medical center. Language services include the following:

- **24-hour access to an interpreter.** We will connect you with someone who speaks your language when you call us to make an appointment or to talk with a medical advice nurse, your doctor, or a Member Services representative.
- **Translation services.** Some member materials may be available in your preferred language. To request member materials in your preferred language, call Member Services.
- **Bilingual physicians and staff.** In some medical centers and facilities, we have bilingual physicians and staff to assist you with your health care needs. You can call Member Services or search online in the medical staff directory at **kp.org**.
- **Telecommunications Relay Service (TRS).** If you are deaf, hard of hearing, or speech impaired, we have TRS access numbers that you can use to make an appointment or talk with an advice nurse, your doctor, or a Member Services representative.
- **Braille or large print.** If you are blind or vision impaired, you can request for documents in Braille or large print by calling Member Services.
- **Sign language interpreter services.** These services are available for appointments.
- **Educational resources.** Selected health promotion materials are available in foreign languages upon request. To access Spanish language information and many educational resources, go to **kp.org/espanol** or **kp.org** to access *La Guía en Español* (*The Guide in Spanish*). You can also look for the ñ symbol on the English language Web page. The ñ points to relevant Spanish content available in *La Guía en Español*.
- **Medicine labels.** Upon request, your pharmacist can provide medicine labels in Spanish for most medications filled at your Kaiser Permanente pharmacy.

The collection of race, ethnicity, and language preference information

To meet our members' linguistic needs and provide culturally appropriate services, we need information to help us create additional programs and resources. As part of our electronic medical record system, we will make efforts to collect demographic and language preference data in a routine manner. When visiting your medical center, you will be asked to provide your demographic information, including race, ethnicity, and language preference.

At Kaiser Permanente, we are committed to providing health care to all our members regardless of their race, ethnic background, or language preference. It will be entirely your choice whether to provide us with your demographic information. The information is confidential and will be used only to improve the quality of care for you and other Health Plan members. The information also enables us to respond to required reporting regulations that ensure nondiscrimination in the delivery of health care.

If you would like additional information, please call Member Services.

We believe that by understanding your cultural and language preferences, we can more easily customize our care delivery and services to meet your specific needs.

Fuel your good health with knowledge

We encourage you to learn more about your physician's background and the quality of area hospitals. Being informed can help you stay healthy. In addition to **kp.org**, there are many other sites that provide helpful information.

To find information about the education, training, and qualifications of your physician, look at the online Find a Doctor page at **kp.org**. You may also call Member Services. Each state requires that physicians be licensed in its jurisdiction in order to practice. The licensing authorities in each state make certain information available. To find out more about the education, training, and licensure status of any physician practicing in our service areas, visit the following sites.

- Maryland, go to **www.mbp.state.md.us/bpqapp**
- Virginia, go to **http://www.vahealthprovider.com/search.asp**
- Washington, DC, go to **https://doh.force.com/ver/s/**

Board certification denotes that a physician has gone beyond the necessary requirements for licensure and has fulfilled certification requirements established by a specialty board. A physician's status of board certified indicates that he or she has the appropriate knowledge, skills, and experience needed to deliver quality care in a specific area of medicine. To verify a physician's board certification status from 1 of the 24 specialty boards accredited by the American Board of Medical Specialties, visit **www.abms.org**. 95% of the physicians in Mid-Atlantic Permanente Medical Group are board certified.[1] Hospitals and nursing facilities are licensed by the jurisdiction in which they operate. In addition, other regulatory or accreditation entities rate quality. To find quality information about a specific hospital, nursing home, or skilled nursing facility, search one of the following:

- The Joint Commission: **jointcommission.org**
- Maryland Health Care Commission: **mhcc.maryland.gov**
- Quality Improvement Organization for the State of Maryland: **qioprogram.org/locate-your-qio**
- Virginia Health Information: **vhi.org**
- Official U.S. government site for people with Medicare: **medicare.gov**

Kaiser Permanente cannot vouch for the accuracy, completeness, or integrity of data provided via commercial websites. (Some sites charge a fee for each query.) Members are urged to exercise caution when gathering information from these sites and/or drawing conclusions about the overall quality of care of a health care provider based exclusively on such data. Data from such sources may not be reliable: It may not be appropriately validated or may lack suitable risk-adjustment methodologies that would neutralize case mix disparities among facilities or practitioners.

[1] Source: American Board of Medical Specialties (ABMS).

Investigation and approval of new and emerging medical technologies

Nearly every day, medical research identifies promising new drugs, procedures, and devices for the diagnosis, prevention, treatment, and cure of diseases. To assist physicians and patients in determining whether a new drug, procedure, or device is medically necessary and appropriate, our Technology Review and Implementation Committee (TRIC), in collaboration with the Interregional New Technologies Committee and The Permanente Medical Group (TPMG) Medical Technology Committee and Regional Utilization Management Committee (RUMC), provides answers to critical questions regarding the indications for use, safety, effectiveness, and relevance of new and emerging technologies.

These interdisciplinary committees who assess and evaluate new and emerging technologies are primary sources of information about the new medical technologies or new uses of existing technology. Various health care professionals, including primary care physicians, specialists, ethicists, research analysts, and managers, serve on the committees. Kaiser Permanente uses a combination of sources to evaluate the safety and efficacy of new/emerging technologies. This includes, but not limited to scientific findings from clinical research or randomized trials, peer-reviewed medical literature, subject matter experts within and external to Kaiser Permanente, information from appropriate government regulatory agencies and professional organizations, position statement and recommendation from government agencies, professional societies, and summaries from organizations that rely on the judgment of experts when determining the safety and effectiveness of new technology, including recommendations of technology assessment organizations. If compelling scientific evidence is found that a new technology is comparable to the safety and effectiveness of the currently available drugs, treatments, procedures, or devices, the committees may recommend that the new technology be implemented internally by Kaiser Permanente and/or authorized for coverage from external sources of care for its indication(s) for use. This technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

The Regional Pharmacy and Therapeutics (P&T) Committee is responsible for developing and implementing policies about drugs and diagnostic testing materials. The major role of the committee is to review drugs and materials for approval or disapproval as well as establishing drug utilization guidelines. The committee includes physicians, medical practitioners, clinical pharmacists, nurses, and a clinical practice guidelines specialist.

The P&T committee may evaluate or reevaluate any drugs approved by the Food and Drug Administration (FDA). Along with medical specialty experts, the P&T committee evaluates and selects those available medications considered to be the most appropriate for patient care. A formulary, or list of approved drugs, is then developed. The formulary development process is based on sound clinical evidence that supports the safe, appropriate, and cost-effective use of drugs.

Experimental and investigational services

A service is experimental or investigational for a member's condition if any of the following statements apply at the time the service is or will be provided to the member.

The service

- Cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA), and such approval has not been granted.
- Is the subject of a current new drug or new device application on file with the FDA, and FDA approval has not been granted.

- Is subject to the approval or review of an Institutional Review Board (IRB) of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services.
- Is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity, or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In making decisions about whether a service is experimental or investigational, the following sources of information may be reviewed:

- The member's medical records.
- Written protocols or other documents related to the service that has been or will be provided.
- Any consent documents the member or member's representative has executed or will be asked to execute to receive the services.
- The files and records of the IRB or similar body that approves or reviews research at the institution where service has been or will be provided and other information concerning the authority or actions of the IRB or similar body.
- The peer-reviewed medical and scientific literature regarding the requested service, as applied to the member's medical condition.
- Technology assessments performed by Kaiser Permanente and external organizations.
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the FDA, the Office of Technology Assessment, other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

Some of the studies are employing retrospective data, that is, the clinical data in our cumulative medical record. These studies are approved by the IRB but do not require informed consent.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., collaborates with the Mid-Atlantic Permanente Medical Group, P.C., and uses the information and analyses described above to decide if a particular service is experimental or investigational.

Note: As a general rule, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., does not provide coverage for experimental services. However, we do cover clinical trials in accordance with your current *Evidence of Coverage*.

Maintaining your privacy

Maintaining the confidentiality of your personal and medical information, whether oral, written, or electronic, is an important part of our commitment to provide you with quality health care. We are just as committed to providing you with a complete description of our privacy policy and how it affects your information.

Annual privacy notice

A complete description of our privacy practices appears in our "Notice of Privacy Practices." Some states require that we provide you with this additional description of our privacy practices on an annual basis. It is designed to inform you about the types of individually identifiable information collected; how such information is used; the circumstances under which we share it within our medical care program; and the circumstances under which nonpublic, personal health and financial information is disclosed to people outside our program.

Our policy

The Kaiser Permanente Medical Care Program is committed to protecting the privacy of its members and patients, including former members and patients. We consider maintaining the confidentiality of your personal health information — which may include race/ethnicity, language, gender ID entity, sexual orientation, pronoun data or genetic information, and financial information important to our mission of providing quality care to members. We maintain policies regarding confidentiality of individually identifiable health and financial information, including policies regarding access to medical records and disclosure of health and financial information. All Kaiser Permanente staff and employees are required to maintain the confidentiality of members' and former members' individually identifiable health and financial information. The unauthorized disclosure of individually identifiable health and financial information is prohibited. Permanente Medical Group physicians, medical professionals, practitioners, and providers with whom we contract are also subject to maintaining confidentiality.

Information collected

We collect various types of nonpublic personal health and financial information, either from you or from other sources, in order to provide health care services and customer service, evaluate benefits and claims, administer health care coverage, and fulfill legal and regulatory requirements.

This includes medical information, medical and hospital records, mental health records, laboratory results, X-ray reports, pharmacy records, and appointment records.

Following are other examples of the types of information we collect:

- Contained on surveys, applications, and related forms, such as your name, address, date of birth, Social Security number, gender, marital status, and dependents.
- About your relationship with Kaiser Permanente, such as medical coverage purchased, medical services received, account balances, payment history, and claims history.
- Provided by your employer, benefits plan sponsor, or association regarding any group coverage you may have.
- From consumer or medical reporting agencies or other sources such as credit history, medical history, financial background, and demographic information.
- From visitors to our websites, such as online forms, site visit data, and online communications.

Uses of shared information

Certain nonpublic personal health and financial information of members and former members will need to be used or shared during the normal course of our doing business and providing you services. We may use or disclose nonpublic personal health and financial information under certain circumstances, which may include the following:

- Personal health and financial information will be shared only with proper written authorization as required by law or as expressly required or permitted by law without written authorization.
- Personal health and financial information will be shared within the Kaiser Permanente Medical Care Program in order to provide services to you and to meet our responsibilities under the law, such as quality assurance, reviewing the competence or qualifications of health care providers, conducting training programs for health care providers, fraud and abuse detection and compliance programs, certification, licensing and credentialing, research, compiling information for use in a legal proceeding, and billing and payment.
- Demographic information such as information from your enrollment application may be shared within our program to enable us to provide customer service or account maintenance in connection with your benefits.

- If you are enrolled in Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., through your employer or an employee organization, we may share certain protected health information (PHI) with them without your authorization, but only when allowed by law. For example, we may disclose your PHI for a workers' compensation claim or to determine whether you are enrolled in the plan or whether premiums have been paid on your behalf.
- Information such as your name, address, or telephone number may be used by the Kaiser Permanente Medical Care Program to tell you about other products or services that might be useful or beneficial to you.
- Under the Fair Credit Reporting Act, we are permitted to share your name, address, and facts about your transactions and experiences with us (such as payment history) within the Kaiser Permanente Medical Program.

Information shared with nonaffiliated third parties

We occasionally disclose nonpublic personal health and financial information of members and former members outside of the Kaiser Permanente Medical Care Program for the following activities:

- State and federal laws generally requires that we disclose health and financial information when disclosure is compelled by a court; a board; a commission or an administrative agency; a party to a proceeding before a court or an administrative hearing pursuant to a subpoena; or other provision authorizing discovery, an arbitrator or arbitration panel, a search warrant, or a coroner.
- State and federal laws also require other disclosures, including, among other things, records of communicable diseases, workers' safety or industrial accident records disclosed to public agencies, birth and death information, and state tumor registries.
- State and federal laws permit the disclosure of health information without patient authorization under specific circumstances, including, among other things: disclosures to providers or health plans for purposes of diagnosis or treatment of a patient (including electronically through a Health Information Exchange network), emergency medical personnel, peer review committees, public licensing agencies, and private accrediting bodies.
- Information may be shared with other companies that perform services on our behalf to develop and mail information to our customers about products and services.

Protecting information

The Kaiser Permanente Medical Care Program protects the confidentiality and security of private information of members and former members. We maintain physical, electronic, and procedural safeguards that comply with federal and state standards to protect your private information and to assist us in preventing unauthorized access to that information. Employee access to personal health and financial information is provided on a business need-to-know basis, such as to make benefit determinations, pay claims, manage care, manage the quality of care, underwrite coverage, administer a plan, or provide customer service.

Regional notice of privacy practices available

Our regional Notice of Privacy Practices (Notice) describes how your medical information may be used and disclosed and how you can get access to it. This Notice is part of the federal Health Insurance Portability and Accountability Act (HIPAA), which took effect in 2003. Protected health information (PHI) is an important part of the HIPAA rule.

We made changes to our Notice of Privacy Practices, effective September 23, 2013. We are required to let you know when we make such changes.

These changes included:

- Expanded definition of protected health information (PHI).
- Addition of our responsibility to notify you if there is a breach of your unsecured PHI.
- Addition of your right to request PHI in electronic format or have it sent to a third party and to request that your treatment PHI not be shared with the health plan as long as you pay for that treatment out of pocket in full.

We've also clarified parts of our privacy practices. These cover:

- How we may use or disclose your PHI to verify your identity, to exchange health information when you are getting treatment someplace else, for underwriting, and for fundraising.
- Instances in which we may request your authorization for use or disclosure of PHI, such as marketing, sale of PHI, and psychotherapy notes.

Kaiser Permanente operates a Health Information Exchange (HIE) network among Kaiser Permanente regions, and also participates in several HIE networks with other health care providers outside of Kaiser Permanente who have electronic medical record systems. Sharing information electronically is a faster way to get your health information to the health care providers treating you, so they can help make treatment decisions for you. You can choose not to have your information shared through our HIE networks at any time. You may do this by contacting Kaiser Permanente Member Services at 2101 E. Jefferson St., Rockville, MD 20852, or by calling toll-free at **1-800-464-4000** (TTY **711**). If you opt out, the health care providers treating you may call Kaiser Permanente to ask that your health information be provided another way, such as by fax, instead of accessing the information through the HIE network.

This applies to fully insured Health Plan members and current/former patients of Kaiser Foundation Hospitals and regional Permanente Medical Groups.

The full regional Notice of Privacy Practices document is accessible online at **kp.org/privacy**. If you have questions or want to request a printed copy, call Member Services.

Case management services

There are multiple case management opportunities available to you. If your expected need is short term, speak to your doctor about a referral to case management. If you are experiencing severe health problems or a newly diagnosed illness that might require extensive intervention over time, your doctor or other caregiver may suggest that you enroll in our Complex Case Management Program. Enrollment in the program is voluntary, and you can discontinue it at any time.

If your needs are appropriate for Complex Case Management and you give consent to participate, a case manager will work with you and/or your caregiver. With your help and input, the case manager will complete an assessment that includes your priorities and preferences. In collaboration with the appropriate providers, the case manager will work with you and a caregiver to establish prioritized goals for a self-management or action plan. The case manager will work with you to establish a communication schedule based on your needs. If you're at risk for a new medical concern, your health is not improving, or your health condition changes suddenly, then the goals will be modified. If new or different tests are required to gauge your

condition, your case manager will help coordinate them.

Depending on the need, case managers provide the following types of assistance:

- Initial assessment, including medication review
- Coordination of care across providers—for example, scheduling appointments, telephone consultations, reminders for screening, tests, etc.
- Care planning based on your needs, priorities, and preferences
- Coaching and monitoring of your health status
- Support and education
- Assistance with access to Kaiser Permanente and community resources

If you would like more information or help, you may call the self-referral phone line at **1-866-223-2347** (toll free). You will be prompted to state your name, phone number, and medical record number, along with your reason for requesting a case manager. You will be called back within two business days.

Self-refer to our disease management program

Do you have diabetes, asthma, depression, high blood pressure, chronic obstructive pulmonary disease (COPD), or coronary artery disease, and want information to help manage your condition? If so, you can self-refer to our disease management program. Within the Washington, DC metro area call **1-703-359-7878** (TTY **711**). Outside the Washington, DC metro area, call **1-800-777-7904** (TTY **711**).

Quality program information

At Kaiser Permanente, we are committed to providing quality, cost effective health care. Our physicians and managers work together to improve care, service, and the overall performance of our organization.

We participate in a number of independent reports on quality of care and service so that you have reliable information about the quality of care we deliver, as well as a method for comparing our performance to other health plans in the region.

The quality reporting that we participate with includes:

- The National Committee for Quality Assurance (NCQA) for health plan accreditation status
- Healthcare Effectiveness Data and Information Set (HEDIS) for clinical effectiveness of care measures of performance
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure health plan member satisfaction

Kaiser Permanente Commercial plans have a status of Accredited through 2023. This health plan accreditation is given only to health plans that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.[1] To see the complete report, visit **ncqa.org**.

Kaiser Permanente Medicare health plan is rated 5 out of 5 Stars in Maryland, Virginia, and Washington, D.C. for 2023 – Medicare's highest possible rating.[2]

To find out more about the quality program or request a copy of the quality program or information, including a report of our progress toward quality improvement goals, call Member Services or visit **kp.org/quality**.

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[1] NCQA awards were not given or endorsed by Medicare. Official CMS Star Ratings can be found at www.medicare.gov. The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality.

[2] Every year, Medicare evaluates plans based on a 5-star rating system.

Utilization management/resource stewardship program

Quality and efficient care through resource stewardship

To ensure that we are good resource stewards of our resources, we have several programs designed to review and continuously improve our systems and the quality of care and the service received by our members.

Commitment to quality and compliance

The Health Plan and medical group regularly screen for quality of care and review how care and services are used to ensure that we remain the leader in quality in the Mid-Atlantic area. We also have staff who review our programs to make sure we are complying with laws and regulations and that we are administering benefits appropriately.

Utilization management at Kaiser Permanente

Personal physicians provide and coordinate medically appropriate care for our members in a timely fashion. Utilization management (UM) is the process Kaiser Permanente uses to work with your personal physician to ensure that authorization necessary for medically appropriate care is provided to you before elective services are done. UM activities occur across all health care settings at Kaiser Permanente, including medical centers, affiliated hospitals, skilled nursing facilities, rehabilitation centers, home health, hospices, chemical dependency centers, emergency rooms, ambulatory surgery centers, laboratories, pharmacies, and radiology facilities.

If you want to find out more about our resource stewardship/UM program, contact a Member Services representative, who can give you information free of charge about the status of a referral or an authorization; give you a copy of our criteria, guidelines, or protocols, free of charge, used for decision making; answer your questions about a denial decision; or connect you with a member of the resource stewardship/UM team. UM staff members are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. UM staff can receive inbound communication regarding UM issues after normal business hours. You may reach UM staff by calling Member Services. When initiating or returning calls regarding UM issues, our staff will identify themselves by name, title, and organization name.

Accessibility is important for all members, including members with special needs. Kaiser Permanente staff have the ability to send and receive messages with deaf, hearing impaired, or speech-impaired members through Member Services.

Non-English-speaking members may discuss UM issues, requests, and concerns through the Kaiser Permanente language assistance program with help from an interpreter, bilingual staff, or the language assistance line. UM staff have the language line programmed into their phones to enhance timely communication with non-English-speaking members. Language assistance services are provided to members at no cost.

Medically appropriate care

Medically appropriate care is defined as care necessary for the diagnosis, treatment, and/or management of a medical condition within accepted standards and performed in a capable setting at the precise time required to treat the member.

Appropriately trained and credentialed physicians will use their expert clinical judgment and/or evidence-based medical criteria in reviewing for medical appropriateness.

Only a physician may make a denial based on medical appropriateness. In the event any service is denied because it does not meet criteria or is not a covered benefit, members may appeal. Please refer to your *Evidence of Coverage* for details regarding your appeal rights, or you may call Member Services.

Coverage for medically necessary care

All covered services must be medically necessary. We will determine when a covered service is medically necessary (the term is defined in your coverage document). You are entitled to appeal our decision if we receive your appeal in the appropriate time frame. Please refer to your *Evidence of Coverage* for details regarding your appeal rights.

Utilization management affirmative statement: Health plan staff and practitioners

The staff of the Health Plan, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., administer benefits, ensure compliance with laws and regulations, screen for quality of care, review how care and services are used, arrange for your ongoing care, and help organize the many facets of your care.

Kaiser Permanente practitioners and health plan professionals make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of the care and service, and existence of health plan coverage. The Health Plan does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. The Health Plan does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage, benefits, or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and services or result in underutilization. In order to maintain and improve the health of our members, all practitioners and health professionals should be especially diligent in identifying any potential underutilization of care or service.

Medicare Part D drug fraud

Many members find it hard to get through the Medicare Part D coverage gap, known as the donut hole, that occurs between the time their drug costs exceed $4,660 (in 2023) but have not reached the catastrophic level of $7,400 (2023). But asking your provider or pharmacist to help you get around the rules is not the answer. While a provider may want to help a member, and may feel that this is in the member's best interest, any such scheme would be considered fraud under Medicare and other federal and state laws. This type of fraud occurs when a provider, pharmacist, or member uses deception, or makes false statements, to obtain benefits under Part D that the member would not otherwise be entitled to receive. Examples of Part D fraud include

- A married couple who ask the provider to write all prescriptions for one spouse, even though some of the medications may be taken by the other spouse, to help reach the threshold.
- A member who asks to have a drug administered in the medical center instead of picking up a prescription to be self-administered at home, even though there is no medical reason the drug cannot be safely administered at home.
- A pharmacist who discounts or waives the copayment for a prescription.
- A provider who alters a diagnosis in order to help a member qualify for certain drugs.
- A provider who indicates that a more expensive brand drug is medically necessary, when a generic or less expensive drug is indicated, in order to reach the threshold more quickly.

The False Claims Act allows the government to impose civil fines of up to $11,000 for each fraudulent prescription and may exclude the provider from participating in Medicare.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-888-777-5536** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

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, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2101 East Jefferson Street, Rockville, MD 20852 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. 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, 1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (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 **1-888-777-5536** (TTY **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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June 2022

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-888-777-5536** (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 **1-888-777-5536** (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 على **1-888-777-5536** (TTY **711**). سيقوم شخص ما يتحدث بمساعدتك. هذه خدمة مجانية العربية.

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 **1-888-777-5536** (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 **1-888-777-5536** (TTY **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

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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 **1-888-777-5536** (TTY **711**). Ta usługa jest bezpłatna.

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Notes

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