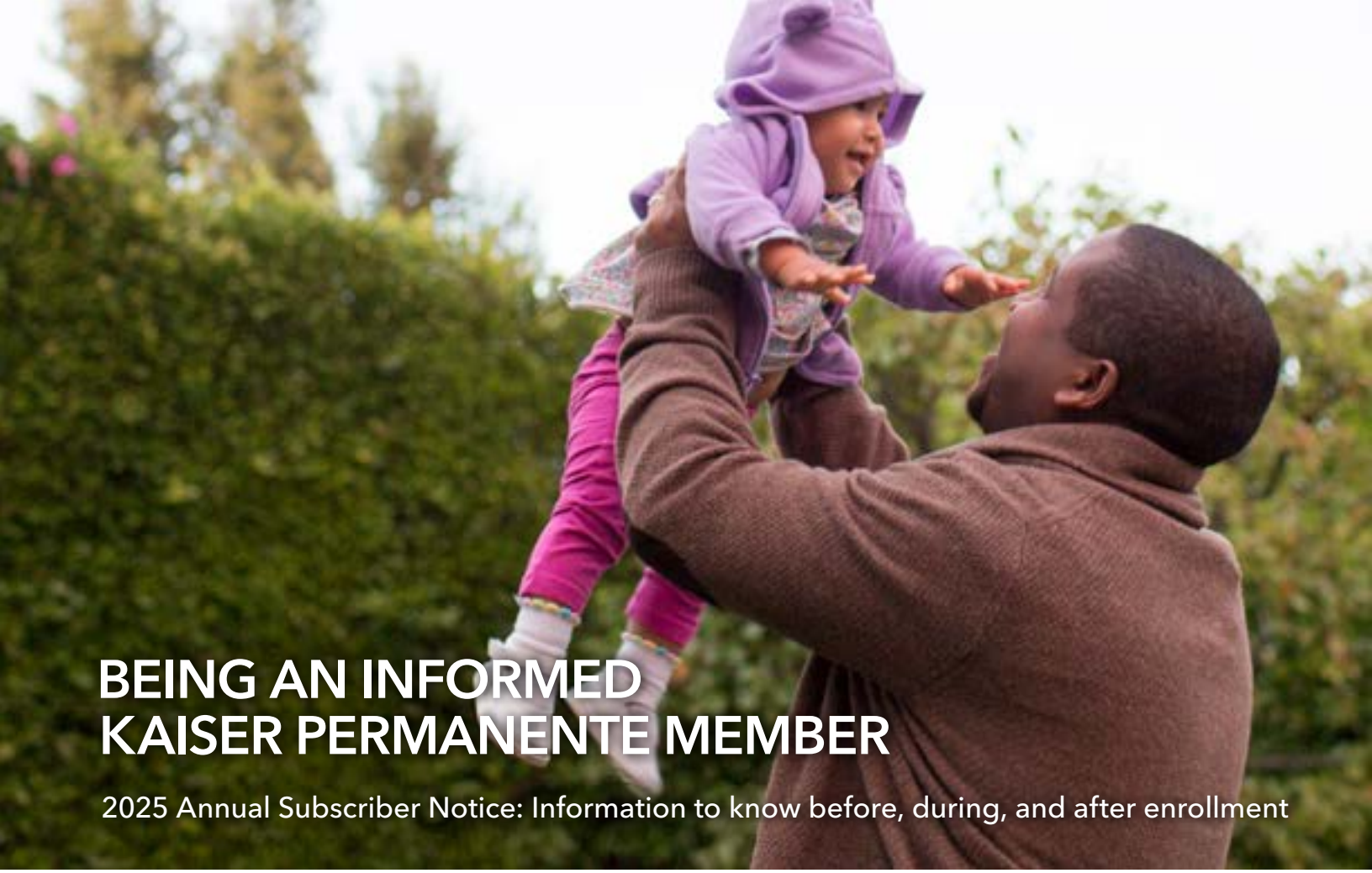

BEING AN INFORMED KAISER PERMANENTE MEMBER

2025 Annual Subscriber Notice: Information to know before, during, and after enrollment

You have the right, at no cost, to receive confidential language assistance services for your health care needs. Upon request, we can arrange for you to speak to an interpreter. If you would like additional information, please call Member Services. You'll find the phone numbers on the back of your ID card.

Tiene derecho a recibir, sin costo, servicios confidenciales de asistencia con el idioma para sus necesidades de atención médica. Si lo solicita, podemos organizarnos para que hable con un intérprete. Si desea obtener información adicional, llame a Servicio a los Miembros. Encontrará los números de teléfono en el reverso de su tarjeta de identificación.

Quý vị có quyền nhận các dịch vụ hỗ trợ ngôn ngữ bảo mật miễn phí nhằm đáp ứng các nhu cầu về chăm sóc sức khỏe của quý vị. Nếu quý vị yêu cầu, chúng tôi có thể sắp xếp để quý vị nói chuyện với một thông dịch viên. Nếu quý vị muốn biết thêm thông tin, vui lòng gọi cho Dịch Vụ Hội Viên. Quý vị sẽ tìm thấy số điện thoại ở mặt sau thẻ Nhận dạng của quý vị.

ለጤና እንክብካቤ ፍላጎቶችዎ ሚስጥራዊ የሆነ የቋንቋ ድጋፍ አገልግሎቶችን የማግኘት መብት ያለ ምንም ወጪ አለዎት። ሲጠይቁን ከአስተርጓሚ ጋር እንዲያነጋግሩ ዝግጅት ማድረግ እንችላለን። ተጨማሪ መረጃ ከፈለጉ እባክዎን ለአባላት አገልግሎት ይደውሉ። የስልክ ቁጥሮችን በመታወቂያ ካርድዎ ጀርባ ላይ ያገኛሉ።

對於您的醫療保健需求，您享有免費獲取保密的語言協助服務的權利。如有需求，我們可以為您安排一名口譯員。如果您想要獲取其他資訊，請致電會員服務部。您可以在您的 ID 卡背面找到其電話號碼。

회원 여러분에게는 의료에 필요한 경우 비밀이 보장되는 언어 지원 서비스를 받을 권리가 있습니다. 요청이 있을 경우 저희는 여러분에게 통역 서비스를 마련해 드릴 수 있습니다. 추가 정보가 필요한 경우, 회원 서비스부로 전화하십시오. 해당 전화번호는 여러분 ID 카드의 뒷면에서 확인할 수 있습니다.

KAISER PERMANENTE®

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The benefits of Kaiser Permanente for specialty care

As a Kaiser Permanente member, you have the advantage of an integrated care experience. In addition, when you receive services at a Kaiser Permanente medical center—including lab, pharmacy, and radiology—electronic capabilities and technology available allow us to keep you connected with all aspects of your care received within Kaiser Permanente. You can access your Kaiser Permanente health information anytime online at **kp.org**.

Prevention

Do you know at what age you should start colorectal cancer screenings? Or when you should have the human papillomavirus (HPV) vaccine? Screening tests and immunizations help you get and stay healthy. Remember to get your annual flu shot.

Your health care team is here to help you make the right choices at the right times. Your preventive care needs depend on your:

- Age
- Gender identity and expression
- Health habits
- Personal health history

We have developed evidence-based guidelines for children and adults. These guidelines support health screening recommendations from organizations such as the U.S. Preventive Services Task Force. Find out what screenings you need at every stage of life online at **kp.org/prevention**. We also recommend that you go to **kp.org/healthyliving/mas** to enjoy the many tools available to you, such as online programs, classes, calculators, health encyclopedias, and much more. Register at **kp.org/register** for access to features that are only available to members.

Contact us

Appointments and 24-hour medical advice

You can schedule, confirm, or cancel appointments at **kp.org**.

You can call to make appointments 24 hours a day, 7 days a week, and 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, **703-359-7878** (TTY **711**).
- Outside the Washington, DC, metro area, **800-777-7904** (TTY **711**). If your doctor is in the community, call his or her office directly.

Registered **kp.org** users can two-way chat real-time with a medical advice nurse 24/7. If you'd like to leave a nonurgent message for a medical advice nurse, as a registered user you can do so at **kp.org**; you'll receive an answer within 24 hours.

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 **800-700-1479.**

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 Monday through Friday, 7:30 a.m. to 9 p.m.

- Within the Washington, DC, metro area, **301-468-6000** (TTY **711**).
- Outside the Washington, DC, metro area, **800-777-7902** (TTY **711**).

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

As a member of Kaiser Permanente, you have the right to do the following:

RECEIVE INFORMATION THAT EMPOWERS YOU TO BE INVOLVED IN HEALTH CARE DECISION MAKING

This includes your right to do the following:

a. Actively participate in discussions and decisions regarding your health care options.

b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved—no matter what the cost is or what your benefits are.

c. Receive relevant information and education that helps promote your safety in the course of treatment.

d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.

e. Refuse treatment, provided that you accept the responsibility for and consequences of your decision.

f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an advance directive, a durable power of attorney for health, a living will, or another health care treatment directive. You can rescind or modify these documents at any time.

g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.

h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your authorized representative will be asked to provide written permission before your records are released, unless otherwise permitted by law.

RECEIVE INFORMATION ABOUT KAISER PERMANENTE AND YOUR PLAN

This includes your right to the following:

a. Receive the information you need to choose or change your primary care physician, including the names, professional levels, and credentials of the doctors assisting or treating you.

b. Receive information about Kaiser Permanente, our services, our practitioners and providers, and the rights and responsibilities you have as a member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies.

c. Receive information about financial arrangements with physicians that could affect the use of services you might need.

d. Receive emergency services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

e. Receive covered, urgently needed services when traveling outside the Kaiser Permanente service area.

f. Receive information about what services are covered and what you will have to pay, and examine an explanation of any bills for services that are not covered.

g. File a complaint, a grievance, or an appeal about Kaiser Permanente, or the care you received, without fear of retribution or discrimination; expect problems to be fairly examined; and receive an acknowledgement and a resolution in a timely manner.

RECEIVE PROFESSIONAL CARE AND SERVICE

This includes your right to the following:

a. See plan providers; get covered health care services; and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.

b. Have your medical care, medical records, and protected health information handled confidentially and in a way that respects your privacy.

c. Be treated with respect and dignity.

d. Request that a staff member be present as a chaperone during medical appointments or tests.

e. Receive and exercise your rights and responsibilities without any discrimination based on age; gender; sexual orientation; race; ethnicity; religion; disability; medical condition; national origin; educational background; reading skills; ability to speak or read English; or economic or health status, including any mental or physical disability you may have.

f. Request interpreter services in your primary language at no charge.

g. Receive health care in facilities that are environmentally safe and accessible to all.

Member responsibilities

As a member of Kaiser Permanente, you have the responsibility to do the following:

PROMOTE YOUR OWN GOOD HEALTH

a. Be active in your health care and engage in healthy habits.

b. Select a primary care physician. You may choose a doctor who practices in the specialty of internal medicine, pediatrics, or family practice as your primary care physician.

c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.

d. Work with us to help you understand your health problems and develop mutually agreed-upon treatment goals.

e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.

f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.

g. Schedule the health care appointments your physician or health care professional recommends.

h. Keep scheduled appointments or cancel appointments with as much notice as possible.

i. Inform us if you no longer live or work within the plan service area.

KNOW AND UNDERSTAND YOUR PLAN AND BENEFITS

a. Read about your health care benefits and become familiar with them. Detailed information about your plan, benefits, and covered services is available in your contract. Call us when you have questions or concerns.

b. Pay your plan premiums and bring payment with you when your visit requires a copayment, coinsurance, or deductible.

c. Let us know if you have any questions, concerns, problems, or suggestions.

d. Inform us if you have any other health insurance or prescription drug coverage.

e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our plan.

PROMOTE RESPECT AND SAFETY FOR OTHERS

a. Extend the same courtesy and respect to others that you expect when seeking health care services.

b. Ensure a safe environment for other members, staff, and physicians by not threatening or harming others.

Filing a claim for reimbursement

You may submit a request for reimbursement of out-of-pocket costs you have incurred for covered services received from physicians, hospitals, or other health care providers as a claim for benefits. Please submit your request to the Health Plan via mail by sending the itemized bills, receipts, and all other supporting documents to:

National Claims Administration-Mid Atlantic States
P.O. Box 371860
Denver, CO 80237-9998

Alternatively, you may send your request via secure fax to **866-568-4184.** However, as image quality may vary when faxing documents, we recommend that you send reimbursement requests via mail. Illegible documents will be returned to the sender with a request to provide clearer documentation in order to continue processing your request.

Reimbursement requests must be submitted to the Health Plan within one year of receipt of the covered services. Failure to submit such a request within one year of receipt of the covered services will not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the request within one year after the date of service, and if the claim is submitted within two years from the date of service. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

Within 30 days of our receiving your request, we will send you an Explanation of Benefits statement detailing what you need to pay and what the Health Plan will pay. You have the right to file an appeal if you disagree with Health Plan's decision not to pay for a claim in whole or in part.

Note: This notice applies only to members covered under contracts sold to businesses and individuals based in Maryland. If your coverage is based in another state, review your contract for specific details on submitting claims for reimbursement. If you have questions, contact Member Services at the telephone number on your member ID card.

Your rights and protections against surprise medical bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

What is balance billing (sometimes called surprise billing)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's, or facility's website or on request.

You are protected from balance billing for:

EMERGENCY SERVICES

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments, and coinsurance). You can't be balance billed for these emergency services. This includes services at the same facility that you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

CERTAIN SERVICES AT AN IN-NETWORK FACILITY

When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services, such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers can't balance bill you and can't ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out of network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: **scc.virginia.gov/pages/File-Complaint-Consumers** or call **877-310-6560.**

Visit **cms.gov/nosurprises** for more information about your rights under federal law.

Consumers covered under (i) a fully insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan, or (iii) a self-funded group that opted in to the Virginia protections are also protected from balance billing under Virginia law. Visit **scc.virginia.gov/pages/Balance-Billing-Protection** for more information about your rights under Virginia law.

Member 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:

Nine Piedmont Center
Attention: Member Relations
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 at **800-777-7902** (TTY **711**).

After business hours, call an advice nurse:

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

NONURGENT APPEALS

Appeals for nonurgent services may be submitted orally or 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

To file an oral appeal, call **800-777-7902** (TTY **711**). Or send your written appeal to:

Kaiser Permanente
Attention: Member Relations
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,* your *Membership Agreement,* or, if you're an FEHB member, the federal brochure *(RI 73-047).*

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 THE DISTRICT OF COLUMBIA

- **Office of Health Care Ombudsman and Bill of Rights**
  One Judiciary Square
  441 4th Street 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

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

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

Choosing your prescription drugs

Kaiser Permanente has a drug formulary, or list of preferred drugs, to help your doctor pick the right drug for you. Our drug formulary includes many drug classes and drugs to treat many medical conditions.

Before including a drug in our drug formulary, a committee of Kaiser Permanente doctors and pharmacists completes a full review of the drug for:

- Safety
- Effectiveness (how well the drug works for the medical condition)
- Therapeutic value (how well the drug works compared to other drugs that may work the same way or similarly)
- Side effects
- Interactions with other drugs
- Cost (when the safety, effectiveness, and side effects of two or more drugs are the same)

Our drug formulary includes brand and generic drugs (generic drugs contain the same active ingredients as brand name drugs) approved by the Food and Drug Administration (FDA) as safe and effective for use. In most cases, your doctor will prescribe a generic drug if one is available. Some drugs on our formulary may have other requirements or limits on coverage depending on your prescription drug benefit. Specific information is included in the drug formulary list. Any potential therapeutic conversion will be discussed with and approved by your doctor before occurring.

If you think you need a drug that is not on our drug formulary (a non-formulary drug), speak with your doctor. The non-formulary exception process is in place to give you and your doctor access to a medically necessary drug under your prescription drug benefit, even when that drug is not on our drug formulary. Your doctor will need to provide evidence that the non-formulary drug is medically necessary or you will be required to pay full price (not just your drug copay) for the non-formulary drug. You can start the non-formulary exception process by calling Kaiser Permanente Member Services at **800-777-7902** (TTY **711**) or by visiting **kp.org** to email your doctor.

If you or your doctor would like to request that a non-formulary drug be considered for addition to our drug formulary or that a formulary drug be removed from our formulary, you can fill out the request form available on **kp.org** or by calling Kaiser Permanente Member Services at **800-777-7902** (TTY **711**).

The cost of drugs may vary depending upon the type of drug and your prescription drug benefit. Details about your prescription drug benefit can be found in the contract for your health benefit plan. If you

have questions or concerns or wish to appeal the cost of a prescription drug or the decision on a non-formulary drug that your doctor did not consider to be medically necessary, you must contact Member Services. Your drug benefits may change from year to year, so be sure to refer to your contract for your health benefit plan's prescription drug benefit.

You can find the most current version of the drug formulary online at **kp.org**, or you can request a copy of our drug formulary by contacting Kaiser Permanente Member Services at **800-777-7902** (TTY **711**).

Changes to the drug formulary may occur regularly based on the monthly Pharmacy and Therapeutics Committee meeting decisions. Please check our website, **kp.org** routinely for any recent updates or changes made to our drug formulary list.

How to potentially reduce the cost of prescription drug copays

As an added benefit, you may save time and money on prescription drug refills with our refill system. Best used for routine (maintenance) drugs, this service allows you to phone in your order. The refill system also allows you to find out if your drug refills are ready.

Call **800-700-1479** toll-free (TTY **703-466-4835**), any time of the day or night, and follow the instructions. If you have refills on your prescription drugs, select the option to have your drug mailed[1] for no additional charge, and you will usually receive your prescription drugs within 3 to 5 business days. For faster service, you can pick up your drug at any of our medical office building pharmacies.

You may be able to receive additional savings when you use the prescription home delivery option. Refer to your contract for complete details about the drug benefits and services available to you.

Fill and track your prescriptions online

Staying on track with your medications is easier when you manage them online. With refill reminders, order tracking, and more, you've got many convenient ways to fill and manage prescriptions—without leaving home.

For most prescriptions, you can skip the trip to the pharmacy and get:

- Refill reminders by text, mobile app notification, or email when your prescriptions are available to order; with text reminders, you can order your refill by replying directly to the message.
- Status updates about delivery information (including shipping issues or delays) by text or email.
- Convenient shipping options, including standard delivery at no extra cost (usually within 3 to 5 days), and same-day or next-day delivery for an additional fee.[1]

Sign in to **kp.org/pharmacy** or the Kaiser Permanente app to manage your prescriptions online.

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

[1]**Note:** There are restrictions on the types of medications we can mail and we do not currently mail to all 50 states due to licensing restrictions. If requesting delivery to a location outside of the Mid-Atlantic States (DC, MD, and VA), please contact prescription home delivery to confirm that they mail to your desired location prior to submitting your prescription refill request.

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 **abms.org**. 95% of the physicians in Mid-Atlantic Permanente Medical Group are board certified. 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**
- U.S. government site for people with Medicare: **medicare.gov**

We also encourage you to review hospital-specific information concerning safety practices. The Leapfrog Group works to identify problems that could harm patients and proposes solutions designed to improve hospital systems and reduce preventable medical mistakes.

The following hospitals affiliated with Kaiser Permanente have completed the Leapfrog Group's Hospital Quality and Safety Survey:

- Reston Hospital Center
- Sinai Hospital
- University of Maryland Medical Center

Survey results are available at **leapfroggroup.org**.

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.

Practitioner information provided to patients

Doctors of medicine, osteopathy, and podiatry who practice in Virginia are required by law to provide patients, at their request, information about how to access provider records pertaining to the provider's education, licensure, specialty, years of active practice, practice address, disciplinary information, and other competency-related information.

To access this information directly, you may contact the Virginia Board of Medicine at **vahealthprovider.com**.

Selecting an adult primary care provider

Members who've turned 18 are of age to choose an adult primary care provider. Members can go to **kp.org/doctor** to choose a primary care provider or can contact Member Services for assistance.

Quality program information

At Kaiser Permanente, we're committed to providing quality, cost-effective health care that is both equitable and accessible to all members and the communities we serve. 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 way to compare our performance with that of other health plans in the region. The quality reporting that we participate in includes:

- National Committee for Quality Assurance (NCQA) for health plan accreditation status
- Healthcare Effectiveness Data and Information Set (HEDIS) for clinical effectiveness of care and measures of performance
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure health plan member satisfaction
- National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction[1] which transitions to Health Equity in 2024[2]

Kaiser Permanente Commercial plans have a status of accredited from the NCQA through 2024 (**ncqa.org** – HP Report Card). This health plan accreditation is given only to health plans that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. To see the complete report, visit **ncqa.org**. The NCQA is the nation's leading watchdog for managed care organizations. 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 at the number on the back of your Kaiser Permanente ID card, or visit **kp.org/quality**.

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 to 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 material may be available in your preferred language. To request member materials in your preferred language, call Member Services at **800-777-7902** (TTY **711**).
- **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 documents in Braille or large print by calling Member Services.
- **Sign language interpretation 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.

[1]In September 2021, NCQA Multicultural Health Care Distinction transitioned to NCQA Health Equity Accreditation.
[2]Kaiser Permanente will participate in the NCQA Health Equity Survey in October 2024.

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 digital health record system, we will make efforts to collect demographic and language preference data in a routine manner. When visiting your medical center, you'll be asked to provide your demographic information, including your race, ethnicity, and language preference.

At Kaiser Permanente, health care teams are now able to document your sexual orientation, gender identity, and pronouns (SOGI) in your medical record. Expanding our data collection to include this additional information will help us to create a more inclusive and supportive health care environment for everyone.

You can also self-identify this information through the **kp.org** member portal. You can find the online questionnaire by visiting **kp.org** and then selecting the "Medical Records" tab. Then scroll down to select "Questionnaires" and choose "Sexual Orientation and Gender Identity Questionnaire." You may also enter your pronouns in this same form. Once complete, this information will be included in your digital health record. Again, this information is confidential and only visible by your health care team.

At Kaiser Permanente, we're committed to providing health care to all our members regardless of their race, ethnic background, language preference, and SOGI identity. 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'd like additional information, please call Member Services at **800-777-7902** (TTY **711**). 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.

Utilization management/resource stewardship program

Quality and efficient care through resource stewardship

To ensure that we are good 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 8 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 at the number on the back of your Kaiser Permanente ID card. 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 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* or *Certificate of Insurance* 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 *Membership Agreement, Evidence of Coverage,* or *Certificate of Insurance* 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 care 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 diligent in identifying any potential underutilization of care or service.

Achieving better health through care management

Through such services as our care management program, we are continuing to build on the idea that the best way for you to achieve better health is to approach your care through early detection and effective management of health conditions. Our care management program gathers and applies successful clinical methods developed by our physicians and combines them with the latest in medical research, technology, and innovations to help improve patient care.

The care management program also offers information on evidence-based medical treatments to support our physicians in managing and preventing the complications of chronic illnesses, such as diabetes, asthma, high blood pressure, depression, and coronary artery disease. Most importantly, through care management, you not only benefit from better health but also gain the confidence and the ability to participate actively in your own care.

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 KPMAS Pharmacy and Therapeutics Committee (P&T Committee), Interregional New Technologies 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 or 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, clinical specialists, medical 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 is 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 currently available drugs, treatmeants, 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 and disapproval as well as establishing drug utilization guidelines. The committee is composed of physicians, medical practitioners, and pharmacists, including clinical practice guideline specialists.

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 *Membership Agreement, Evidence of Coverage,* or contract.

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 **866-223-2347** (toll-free).

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 **703-359-7878** (TTY **711**). Outside the Washington, DC, metro area, call **800-777-790**4 (TTY **711**).

Referrals to specialists

Permanente physicians and other plan providers offer primary care, pediatric services, obstetric-gynecological services, and specialty care—including but not limited to orthopedics, general surgery, dermatology, neurology, cardiology, and gastroenterology. If your primary care physician decides, in consultation with you, that you require medically necessary and appropriate services, you may be referred to a Kaiser Permanente physician or other plan provider for that service. The referral that has been entered by your primary care provider or attending specialist must be authorized before you receive nonemergency specialty care services. Referrals are reviewed and authorized by the utilization management team, which consists of referral nurses, physical therapists, physicians, and support staff. Your primary care physician or attending specialist may refer you to a non-plan provider. Services from non-plan providers will be authorized only if not available from plan providers. You must have an authorized referral to the non-plan provider in order for us to cover the services and/or supplies. If the referral to a non-plan provider is appropriately authorized, you pay only the copayments you would have paid if a plan provider had provided the service and/or supplies. Examples of services requiring authorization or notification include but are not limited to the following:

- Inpatient admissions, including those for childbirth, behavioral health, and chemical dependency (inpatient admissions are those hospital visits for which members are admitted to a facility for 24 hours or more).
- Specialized services, such as home health, medical equipment and associated supplies, and hospice care.
- Skilled nursing and acute rehabilitation facilities.
- Nonemergency medical transportation.
- Care received from a practitioner or facility that does not have a contract with Kaiser Permanente.
- Nonemergency care received outside of the Kaiser Permanente service area. Emergency services (inside and outside our service area) do not require a referral from a primary care physician. You do not need to obtain care from a plan provider.

If your provider decides that you need covered services from a specialist, your provider will request a referral for you. If you did not receive a referral during your visit and you would like to request one, please call Member Services at **800-777-7902** (TTY **711**) to start the process. You will receive a decision on your requested referral whether the referral is approved or denied.

If you have any questions regarding the status of your referral or denied services or would like to request a copy of any guideline or other criteria (provided free of charge) used in any decision regarding your care, please contact Member Services at **800-777-7902** (TTY **711**).

Self-referrals

You can self-refer:

- To a plan physician who specializes in obstetric-gynecological care.
- For routine vision services provided in a plan provider's office.

- For the initial consultation with a behavioral health provider for behavioral health or chemical dependency services (call the Behavioral Health Access Unit toll-free at **866-530-8778**). Thereafter, the provider may have to get prior authorization in order to continue providing services.
- For dental services, only if you are a member who has purchased a Kaiser Permanente dental rider benefit. Although a referral is not required to access care from these providers, the provider may have to get prior authorization for certain services.

Provider directory information

Provider information is accurate at the time of publication. If you identify inaccurate provider information in the online or printed provider directory and would like to report it, please call **877-806-7470** toll-free, or email the information to **provider.relations@kp.org**.

Care for mothers and newborns under the Newborns' and Mothers' Health Protection Act

Kaiser Permanente offers coverage (consistent with the mother's policy terms) for inpatient hospitalization services for a mother and newborn child for a minimum of

- 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery
- 96 hours of inpatient hospitalization care after an uncomplicated cesarean birth

If the mother and newborn remain in the hospital for at least the length of time provided, coverage includes a home visit if prescribed by the attending physician. The mother may request a shorter length of stay if, after talking with her physician, she decides that less time is needed for her recovery.

If the mother and newborn have a shorter hospital stay than listed above, coverage includes one home visit scheduled to occur within 24 hours after hospital discharge and an additional home visit if prescribed by the attending physician.

Women's health care services in the District of Columbia

This article summarizes the coverage and cost-sharing information for women's health care services that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is providing for health plan members in Washington, DC.

- All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity are covered under preventive care at no charge.
- Coverage at no charge for contraceptive drugs, devices, products, and services, including those obtained over the counter and those prescribed. Members may obtain up to a 12-month supply of prescription contraceptive drugs all at once or over the course of the 12 months at the patient's election.
- Coverage at no charge for the following preventive health services and products:
  a. Breast cancer screening
  b. Breast feeding support, services, and supplies
  c. Screening for cervical cancer, including HPV testing
  d. Screening for gestational diabetes
  e. Screening and counseling for HIV
  f. Screening and counseling for interpersonal and domestic violence
  g. Screening and counseling for sexually-transmitted diseases
  h. Screening and counseling for Hepatitis B and C
  i. Well-woman preventive visits, including visits to obtain necessary preventive care, preconception care, and prenatal care
  j. Folic acid supplementation
  k. Breast cancer chemoprevention counseling and preventive medications
  l. Risk assessment and genetic counseling and testing using the Breast Cancer Risk Assessment tool approved by the National Cancer Institute
  m. Rh incompatibility screening during pregnancy
  n. Evidence-based items, services, prescription-drug items that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force as of September 19, 2017
  o. Any additional health services and products including contraceptive drugs, devices, and products identified by rules issued pursuant to DC Code §31-3834.02 subsection (c)

No charge denotes that services and products will be provided to the member at no cost even if the plan deductible is not yet met. This results in no financial responsibility for the member.

Exemptible Benefit Notice: An employer organized and operating as a nonprofit entity and referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, approved October 22, 1986 (100 Stat. 2740; 26 U.S.C. § 6033(a)(3)(A)(i) or (iii)), may be exempt from any requirement to cover contraceptive drugs, devices, products, and services under §§ 31-3834.01, 31-3834.02, and 31-3834.03.

Habilitative services

Kaiser Permanente provides coverage for habilitative services to members until at least the end of the month in which the member turns 19 years of age. Habilitative services include devices and services such as behavioral health treatment, psychological care, and therapeutic care that assist members to learn, keep, or improve skills and functioning for daily life. Kaiser Permanente must preapprove all habilitative services. Any deductibles, copayments, and coinsurance required under your contract apply. Policy maximums and benefit limits apply. Habilitative services are not counted toward any visit maximum for therapy services. Please note that any therapies provided through the school system are not covered by this benefit. Please check your contract for specific details regarding your habilitative benefits.

This coverage notice applies only to contracts sold to businesses and individuals based in Maryland. If your coverage is based in another state, your plan includes coverage for habilitative services; however, please check your contract to learn what services and benefits you are eligible to receive. If you have questions regarding any of these services, contact Member Services at the telephone number on your member ID card.

Home visits after surgery

Kaiser Permanente provides coverage for home visits to members who undergo the surgical removal of a testicle. Coverage includes one home visit that occurs within 24 hours after discharge from the hospital or outpatient facility and an additional home visit if prescribed by the member's doctor. To be eligible, the member must be in the hospital less than 48 hours or have the procedure performed on an outpatient basis.

This coverage notice applies only to contracts sold to businesses and individuals in Maryland. Please check your contract coverage to determine if you are eligible for these surgical procedure benefits.

Proposed rate increases

If your coverage is through a Maryland-based small employer or if you are covered under a Maryland individual health benefit plan, you should know that you:

- May access information about Kaiser Permanente's proposed rate changes/increases
- May submit comments on the proposed rate changes/increases on the Maryland Insurance Administration website at **healthrates.mdinsurance.state.md.us**

Hospitalization and home visits following a mastectomy

Kaiser Permanente provides benefits for reconstructive breast surgery related to a mastectomy as required by the federal Women's Health and Cancer Rights Act of 1998. Coverage for reconstructive surgery includes mastectomy-related benefits, such as:

- All stages of reconstruction of the breast that underwent the mastectomy
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis (artificial breast) and treatment of the physical complications that occur at all stages of the mastectomy, including lymphedema (swelling)

In addition, Maryland law requires that coverage include inpatient hospitalization for a minimum of 48 hours following a mastectomy. If this is applicable to you, you may request a shorter length of stay if, after talking with your physician, you decide that less time is needed for your recovery. If you have a shorter hospital stay than listed above, coverage includes one home visit scheduled to occur within 24 hours after your discharge from the hospital or outpatient facility and an additional home visit if prescribed by your attending physician.

For more information about Kaiser Permanente member benefits and services, please call Member Services at **800-777-7902** (TTY **711**).

Mental illness, emotional disorders, and substance abuse benefits

If you are a member covered under a Maryland-based contract, Kaiser Permanente covers benefits for the diagnosis and treatment of mental illness, emotional disorders, and substance use disorders as required under Maryland law and, as applicable, the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Compliance with these laws means we cover benefits for the diagnosis and treatment of mental illness, emotional disorders, and substance use disorders under the same terms and conditions as provided for covered benefits for the treatment of physical illnesses.

The benefits for mental illness, emotional disorders, and substance use disorders are described in your coverage contract. Please refer to your *Evidence of Coverage*, *Membership Agreement,* or *Certificate of Insurance*, as appropriate, for specific details regarding your benefits for these illnesses.

If you have questions or need further information about the benefits for mental illness, emotional disorders, and substance misuse required under Maryland law and/or under the federal Mental Health Parity and Addiction Equity Act of 2008, you may contact the Maryland Insurance Administration at the address and telephone number listed below:

Maryland Insurance Administration
200 Saint Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2000
800-492-6116 (toll-free)
800-735-2258 (TTY)

Important information regarding advance directives

It's important for all adults to plan for life's "what ifs." If you suddenly became injured or ill, would you be prepared? Who would speak for you if you were unable to speak for yourself? At Kaiser Permanente, we encourage all adult members to choose a health care agent (decision-maker) who can represent you and your health care wishes if you are ever unable to do so. Have a conversation with your health care agent and loved ones about these wishes, and record them in a document called an advance directive.

Life-threatening illness can be a difficult subject to discuss, but the conversation is just as important as the actual document. Planning ahead can help ensure your health care choices are respected, in addition to easing potential burdens on family and friends. Be sure to discuss such wishes with those close to you, including your Kaiser Permanente physicians. Kaiser Permanente has a service called Life Care Planning that can help you with this process. Also, advance directive forms are available at each of our medical offices throughout the region for you to document future health care decisions. You can also download an advance directive form from our life care planning website, **kp.org/lifecareplan**. After the form is completed, it can be easily uploaded to your medical record through your **kp.org** account. Additional information about Life Care Planning and advance directives is available at **kp.org/lifecareplan**, and you can get even more information and resources for advance directives by calling **888-594-7437,** and by visiting these regional advance directive resources:

District of Columbia: **www.caringinfo.org/planning/advance-directives/by-state/district-of-columbia**

Maryland: **www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx**

Virginia: **www.virginiaadvancedirectives.org**

Your right to decide

Adults can decide for themselves whether they want medical treatment. This right to decide—to say yes or no to proposed treatment—applies to treatments that extend life, like a breathing machine or a feeding tube. Tragically, accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your own values and priorities.

A Maryland law called the Health Care Decisions Act says that you can do health care planning through "advance directives." An advance directive can be used to name a health care agent. This is someone you trust to make health care decisions for you. An advance directive can also be used to say what your preferences are about treatments that might be used to sustain your life.

The State offers a form to do this planning, included with this pamphlet. The form as a whole is called "Maryland Advance Directive: Planning for Future Health Care Decisions." It has three parts to it: Part I, Selection of Health Care Agent; Part II, Treatment Preferences ("Living Will"); and Part III, Signature and Witnesses.

The advance directive is meant to reflect your preferences. You may complete all of it, or only part, and you may change the wording. You are not required by law to use these forms. Different forms, written the way you want, may also be used. For example, one widely praised form, called Five Wishes, is available (for a small fee) from the nonprofit organization Aging with Dignity. You can get information about that document from the internet at **agingwithdignity.org** or write to:

Aging with Dignity
P.O. Box 1661
Tallahassee, FL 32302

This optional form can be filled out without going to a lawyer. But if there is anything you do not understand about the law o your rights, you might want to talk with a lawyer. You can also ask your doctor to explain the medical issues, including the potential benefits or risks to you of various options. You should tell your doctor that you made an advance directive and give your doctor a copy, along with others who could be involved in making these decisions for you in the future.

In Part III of the form, you need two witnesses to your signature. Nearly any adult can be a witness. If you name a health care agent, though, that person may not be a witness. Also, one of the witnesses must be a person who would not financially benefit by your death or handle your estate. You do not need to have the form notarized.

The Maryland Advance Directive also includes an optional section called "After My Death." This section has four parts to it: Part I, Organ Donation; Part II, Donation of Body; Part III, Disposition of Body and Funeral Arrangements; and Part IV, Signature and Witnesses.

Once you make an advance directive, it remains in effect unless you revoke it. It does not expire, and no one except you can change it. You should review what you've done once in a while. Things might change in your life, or your attitudes might change. You are free to amend or revoke an advance directive at any time, as long as you still have decision-making capacity. Tell your doctor and anyone else who has a copy of your advance directive if you amend it or revoke it.

If you already have a prior Maryland advance directive, living will, or a durable power of attorney for health care, that document is still valid. Also, if you made an advance directive in another state, it is valid in Maryland. You might want to review these documents to see if you prefer to make a new advance directive instead.

Part I of the advance directive: Selection of health care agent

You can name anyone you want (except, in general, someone who works for a health care facility where you are receiving care) to be your health care agent. To name a health care agent, use Part I of the advance directive form. (Some people refer to this kind of advance directive as a "durable power of attorney for health care.") Your agent will speak for you and make decisions based on what you would want done or your best interests. You decide how much power your agent will have to make health care decisions. You can also decide when you want your agent to have this power right away, or only after a doctor says that you are not able to decide for yourself.

You can pick a family member as a health care agent, but you don't have to. Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care agent. Also, consider picking one or two back-up agents, in case your first choice isn't available when needed. Be sure to inform your chosen person and make sure that he or she understands what's most important to you. When the time comes for decisions, your health care agent should follow your written directions.

We have a helpful booklet that you can give to your health care agent. It is called *Making Medical Decisions for Someone Else: A Maryland Handbook*. You or your agent can get a copy on the Internet by visiting the Attorney General's homepage at **marylandattorneygeneral.gov**, then clicking on "Guidance for Health Care Proxies." You can request a copy by calling **410-576-7000.**

The form included with this pamphlet does not give anyone power to handle your money. We do not have a standard form to send. Talk to your lawyer about planning for financial issues in case of incapacity.

Part II of the advance directive: Treatment preferences ("living will")

You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. You can do this in Part II of the form. If you both name a health care agent and make decisions about treatment in an advance directive, it's important that you say (in Part II, paragraph G) whether you want your agent to be strictly bound by whatever treatment decisions you make.

Part II is a living will. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and end-stage condition, which is an advanced, progressive, and incurable condition resulting in complete physical dependency. One example of end-stage condition could be advanced Alzheimer's disease.

How physicians are paid

Our compensation to physicians who offer health care services to our insured members or enrollees may be based on a variety of payment mechanisms, such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods. If you desire additional information about our methods of paying physicians, or if you want to know which method(s) apply to your physician, please call Kaiser Permanente at ***800-777-7902*** *(TTY* ***711****) or write to:*

Kaiser Permanente Member Services
2101 E. Jefferson St.
Rockville, MD 20852

How Kaiser Permanente physicians are paid

Definitions of how health plans may pay physicians for your health care services, with a simple example of how each payment mechanism works. The example shows how Dr. Jones, an obstetrician-gynecologist, would be compensated under each method of payment.

Salary 0%[1]	A physician is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of an HMO, she receives her usual biweekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by cesarean birth, a more complicated procedure than a vaginal delivery, the method of delivery will not have any effect upon Dr. Jones' salary.
Capitation 95%[1]	Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones' monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.
Fee-for-service 0%[1]	A physician charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract, and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder. Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services and the time she spends providing services to Mrs. Smith. Because cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.
Discounted fee-for-service 5%[1]	Payment is less than the rate usually received by the physician for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs, and the physician, who usually gets an increased volume of patients. Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but, under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that, in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.

[1]Health Plan contracts exclusively with Mid-Atlantic Permanente Medical Group, P.C. (MAPMG or Permanente), which employs approximately 1,700 full- and part-time physicians. MAPMG provided more than 96% of physician services to Kaiser Permanente enrollees in 2021. MAPMG receives budgeted prepayment calculated according to expected membership and utilization; this method of compensation is not capitation as defined by Maryland insurance regulation. This arrangement may not be adequately reflected in the categories of compensation shown above.

Bonus 0%[1]	A physician is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or another type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs, and use of services. An HMO rewards its physician staff or contracted physicians who have demonstrated higher-than-average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.
Case rate 0%[1]	The HMO or insurer and the physician agree in advance that payment will cover a combination of services provided by both the physician and the hospital for an episode of care. This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery and hospital-related charges, are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

Compensation for providers of behavioral health care services

It is important to us that you understand how providers of behavioral health care services are paid. We provide our members with access to behavioral health care services through different types of providers, who are compensated in different ways. We compensate each provider depending on his or her relationship to the Health Plan. These relationships include the following:

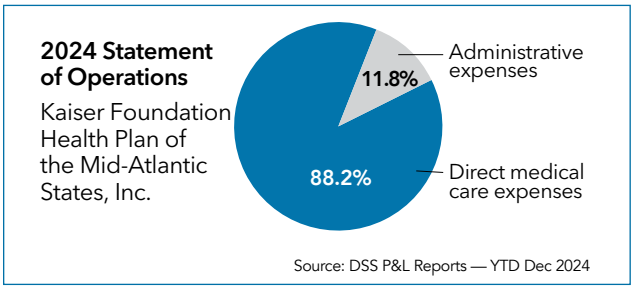
- Providers, such as social workers and clinical psychologists, who are employees of the Health Plan and are paid a salary
- Physicians of the Mid-Atlantic Permanente Medical Group, P.C. (MAPMG), who are paid a salary by MAPMG, which receives a capitated payment from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., to provide physician services to our members
- Contracted providers who receive discounted fee-for-service payments for services rendered to members
- A managed behavioral health care organization that is compensated on a discounted fee-for-service basis

This arrangement is the result of an agreement among the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.; MAPMG; and the managed behavioral health care organization. If you would like more information about our methods of paying providers, or if you want to know which methods apply to your provider, please contact Member Services at **800-777-7902** (TTY **711**). You can also write to us:

Kaiser Permanente Member Services
2101 E. Jefferson St.
Rockville, MD 20852

How premium dollars are spent

In order for you to evaluate and compare health plan choices, we believe you should be given information on a variety of topics. It is important to us that you understand how much of your premium dollar is going to health care delivery costs rather than plan administration, profits, or other uses. See the chart for details about how your premium dollars are spent.



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, including 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 federal 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 Care 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 law 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 law also requires 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 law permits 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), which you have received, 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 went into law in 2003. Protected health information 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.

The full regional *Notice of Privacy Practices* document is accessible online via **https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/privacy-practices**.

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 **800-464-4000** or **301-879-6380** (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.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan 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 **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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.

In the event of dispute, the provisions of the approved English version of the form will control.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poò bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **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 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).

Kaiser Permanente medical facilities

Maryland

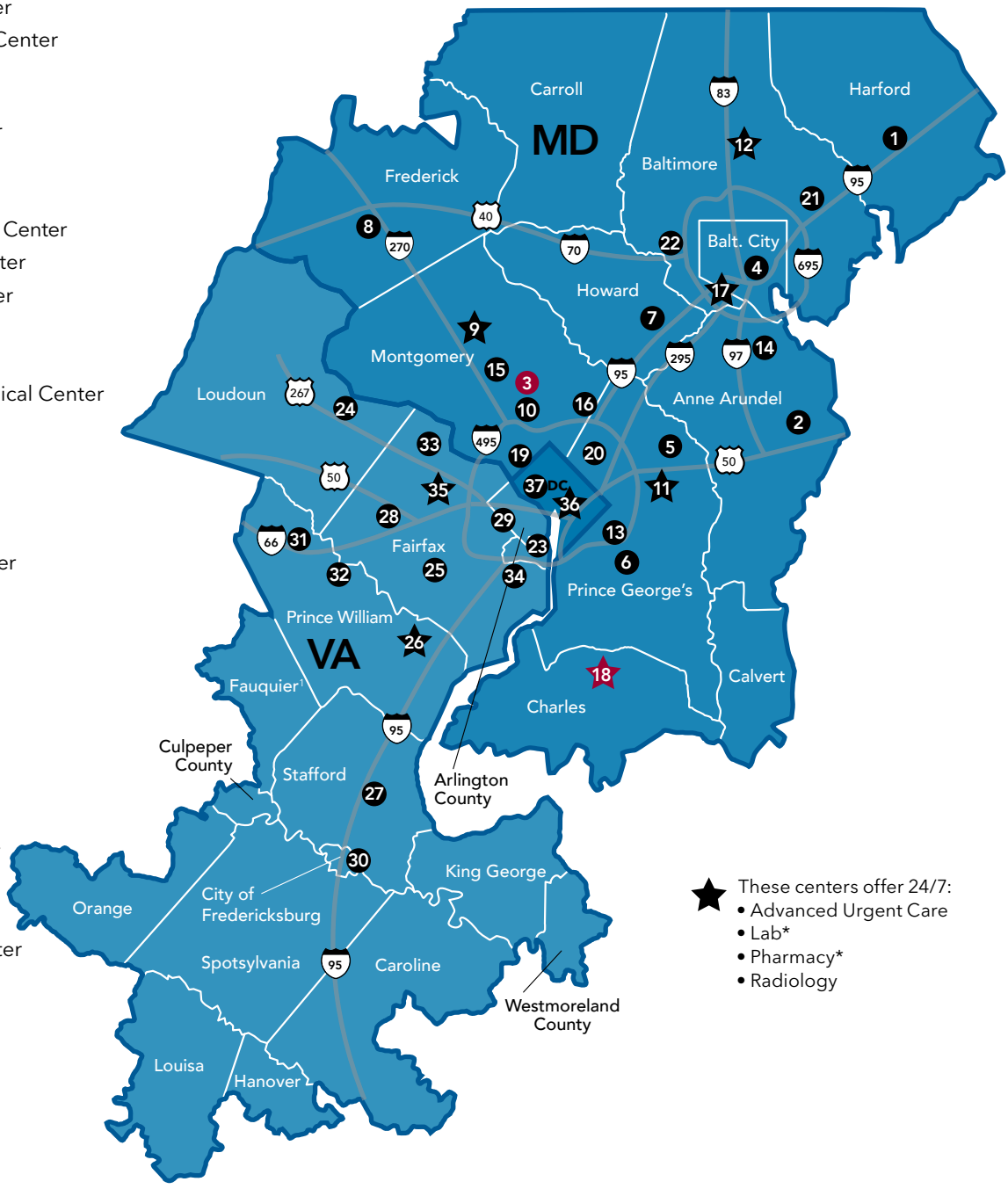
1 Abingdon Medical Center
2 Annapolis Medical Center
3 **FUTURE LOCATION**
Medical Center in Aspen Hill
4 Kaiser Permanente Baltimore Harbor Medical Center
5 Bowie Fairwood Medical Center
6 Camp Springs Medical Center
7 Columbia Gateway Medical Center
8 Kaiser Permanente Frederick Medical Center
9 Gaithersburg Medical Center
10 Kensington Medical Center
11 Largo Medical Center
12 Lutherville-Timonium Medical Center
13 Marlow Heights Medical Center
14 North Arundel Medical Center
15 Shady Grove Medical Center
16 Silver Spring Medical Center
17 South Baltimore County Medical Center
18 **FUTURE LOCATION**
Medical Center in Waldorf
19 well Friendship Heights by KAISER PERMANENTE
20 West Hyattsville Medical Center
21 White Marsh Medical Center
22 Woodlawn Medical Center

Virginia

23 Alexandria Medical Center
24 Ashburn Medical Center
25 Burke Medical Center
26 Caton Hill Medical Center
27 Colonial Forge Medical Center
28 Fair Oaks Medical Center
29 Falls Church Medical Center
30 Fredericksburg Medical Center
31 Haymarket Crossroads Medical Center
32 Manassas Medical Center
33 Reston Medical Center
34 Springfield Medical Center
35 Tysons Corner Medical Center

Washington, DC

36 Kaiser Permanente Capitol Hill Medical Center
37 Northwest DC Medical Office Building



*Extended pharmacy hours at Gaithersburg and Lutherville-Timonium and extended lab hours at Tysons Corner.

For our most up-to-date listing of facilities and services available, please check **kp.org/facilities**.

[1]Kaiser Permanente's service area in Fauquier County includes the following ZIP codes: 20115, 20116, 20117, 20119, 20128, 20137, 20138, 20139, 20140, 20144, 20181, 20184, 20185, 20186, 20187, 20188, 20198, 22406, 22556, 22639, 22642, 22643, 22720, 22728, and 22739.

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