

2026

Medicare Health Plan Annual Subscriber Notice

Be an informed Kaiser Permanente member

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Contact us

Member Services

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

Appointments and 24-hour medical advice

You can call to make appointments 24 hours a day, 7 days a week. Medical advice is also available 24 hours a day, 7 days a week.

For either of these services, call:

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

If your doctor is in the community, call his or her office directly. Registered **kp.org** users can two-way chat real-time with a medical advice nurse 24/7.

Prescription refills

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

How to access a list of providers

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

Get Care - Virtual Care

Your Kaiser Permanente doctor, specialists, and health plan are all part of one connected team—coordinating your care seamlessly so you don't have to and providing you access to care from the comfort and safety of your own home. Let's review how your health plan will support you.

You can't always plan on when you'll need care.

That's why Kaiser Permanente offers many convenient ways to get you the care you need, on your time, where you are for low to no cost.

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

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

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

Not sure which kind of care is right for you?

Advice is available 24/7. Just visit **kp.org/getcare** or call us to talk to a licensed care provider anytime.

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

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

Member rights and responsibilities:

Our commitment to each other

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

Member rights: Our plan must honor your rights and cultural sensitivities

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

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

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

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

If providers in our network for a specialty are not available, it is our responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing.

If you find yourself in a situation where there are no specialists in our network that cover a service you need, call us for information on where to go to obtain this service at in-network cost-sharing.

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

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

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

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, your *Evidence of Coverage* tells you what you can do.

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

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

- Your "personal health information" includes the personal information you gave us when you enrolled in our plan as well as your

medical records and other medical and health information.

- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practices,” that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a

fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

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

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

As a member of our plan, you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about our plan’s financial condition.
- **Information about our network providers, and pharmacies.**
 - You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network. For a list of providers and pharmacies in our network, visit kp.org/directory.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In your *Evidence of Coverage*, we explain what medical services and Part D prescription drugs are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - If you have questions about the rules or restrictions, please call Member Services.

- **Information about why something is not covered and what you can do about it.**
 - Your *Evidence of Coverage* provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Your *Evidence of Coverage* also provides information on asking us to change a decision, also called an appeal.

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other

medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.

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

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

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

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives.**” Documents like “**living wills**” and “**powers of attorney for health care**” are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** No matter where you get this form, it’s a legal document. Consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** Give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

If your instructions aren't followed

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

District of Columbia residents

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

Maryland residents

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

Virginia residents

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

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

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

7. If you believe you're being treated unfairly, or your rights aren't being respected

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

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

- **Call Member Services** at **1-888-777-5536** (TTY **711**).
- **Call your State Health Insurance Agency (SHIP):**
 - Maryland Department of Aging: **1-410-767-1100** or toll free **1-800-243-3425** (TTY **711**)
 - District of Columbia Department of Aging and Community Living: **1-202-724-5626** (TTY **711**)
 - Virginia Insurance Counseling and Assistance Program: **1-804-662-9333** or toll free **1-800-552-3402** (TTY **711**).
- **Call Medicare** at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

8. How to get more information about your rights

Get more information about your rights from these places when you:

- **Call Member Services at 1-888-777-5536 (TTY 711)**
- **Call your State Health Insurance Agency (SHIP):**
 - Maryland Department of Aging: **1-410-767-1100** or toll free **1-800-243-3425 (TTY 711)**
 - District of Columbia Department of Aging and Community Living: **1-202-724-5626 (TTY 711)**
 - Virginia Insurance Counseling and Assistance Program: **1-804-662-9333** or toll free **1-800-552-3402 (TTY 711)**.
- **Contact Medicare:**
 - Visit **www.Medicare.gov** to read the publication *Medicare Rights & Protections* (available at: **www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf**)
 - Call **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**)

9. Information about new technology assessments

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

10. You can make suggestions about rights and responsibilities

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

Your responsibilities as a member of our plan

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use your *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
 - Your *Evidence of Coverage* gives details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Your *Evidence of Coverage* gives details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.**
 - Your *Evidence of Coverage* tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health care providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must continue to pay a premium for your Medicare Part B to remain a member of our plan.
 - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of our plan.
- **If you move within your plan’s service area,** we need to know so we can keep your membership record up-to-date and know how to contact you.
- **If you move outside of your plan’s service area,** you cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Member compliment and complaint procedures

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

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

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

Written compliments or complaints should be sent to:

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

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

Method	Member Services - contact information
Call	1-888-777-5536
	Calls to this number are free, 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711
	Calls to this number are free, 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Website	kp.org

Medically urgent situations

How to file an urgent appeal

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

After business hours, call an advice nurse

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

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 **1-800-777-7904** (TTY **711**). Or send your written appeal to::

Kaiser Permanente
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*.

Right to independent review

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

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

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

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

IN MARYLAND

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

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

IN VIRGINIA

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

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

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

IN THE DISTRICT OF COLUMBIA

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

FOR FEDERAL EMPLOYEES

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

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

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

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

The formulary and/or provider network may change at any time. You will receive notice when necessary.

contact Member Services or refer to your *Evidence of Coverage*.

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

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

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

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

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

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

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

Language services

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

- **24-hour access to an interpreter.** We will connect you with someone who speaks your language when you call us to make an appointment or to talk with a medical advice nurse, your doctor, or a Member Services representative.
- **Translation services.** Some member materials may be available in your preferred language. To request member materials in your preferred language, call Member Services.

The formulary and/or provider network may change at any time. You will receive notice when necessary.

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

The collection of race, ethnicity, and language preference information

To meet our members' linguistic needs and provide culturally appropriate services, we need information to help us create additional programs and resources. As part of our 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 **1-800-777-7902 (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.

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:
<http://www.vahealthprovider.com/search.asp>
- Washington, DC:
<https://doh.force.com/ver/s/>

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

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

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

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

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

and appropriate, our Technology Review and Implementation Committee (TRIC), in collaboration with the 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 and emerging technologies are primary sources of information about the new medical technologies or new uses of existing technology. Various health care professionals, including primary care physicians, 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 the currently available drugs, treatments, procedures, or devices, the committees may recommend that the new technology be implemented internally by Kaiser Permanente and/or authorized for coverage from external sources of care for its indication(s) for use. This technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

The Regional Pharmacy and Therapeutics (P&T) Committee is responsible for developing and implementing policies about drugs and diagnostic testing materials. The major role of the committee is to review drugs and materials for approval or disapproval as well as establishing drug utilization guidelines. The committee 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 *Evidence of Coverage*.

Maintaining your privacy

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

Annual privacy notice

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

Our policy

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

and providers with whom we contract are also subject to maintaining confidentiality.

Information collected

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

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

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

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

Uses of shared information

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

information under certain circumstances, which may include the following:

- Personal health and financial information will be shared only with proper written authorization as required by law or as expressly required or permitted by law without written authorization.
- Personal health and financial information will be shared within the Kaiser Permanente Medical Care Program in order to provide services to you and to meet our responsibilities under the law, such as quality assurance, reviewing the competence or qualifications of health care providers, conducting training programs for health care providers, fraud and abuse detection and compliance programs, certification, licensing and credentialing, research, compiling information for use in a legal proceeding, and billing and payment.
- Demographic information such as information from your enrollment application may be shared within our program to enable us to provide customer service or account maintenance in connection with your benefits.
- If you are enrolled in Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., through your employer or an employee organization, we may share certain protected health information (PHI) with them without your authorization, but only when allowed by law. For example, we may disclose your PHI for a workers' compensation claim or to determine whether you are enrolled in the plan or whether premiums have been paid on your behalf.
- Information such as your name, address, or telephone number may be used by the Kaiser Permanente Medical Care Program to tell you about other products or services that might be useful or beneficial to you.
- Under the Fair Credit Reporting Act, we are permitted to share your name, address, and facts about your transactions and experiences with us (such as payment history) within the Kaiser Permanente Medical Program.

Information shared with nonaffiliated third parties

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

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

Protecting information

The Kaiser Permanente Medical Care Program protects the confidentiality and security of private information of members and former members. We maintain physical, electronic, and procedural safeguards that comply with federal and state standards to protect your private information and to assist us in preventing unauthorized access to that information.

Employee access to personal health and financial information is provided on a business need-to-know basis, such as to make benefit determinations, pay claims, manage care, manage the quality of care, underwrite coverage, administer a plan, or provide customer service.

Regional notice of privacy practices available

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

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 4000 Garden City Drive, Hyattsville, MD 20785, or by calling toll-free at **1-800-464-4000 (TTY 711)** or **1-301-879-6380 (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.

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

Case management services

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

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

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

- Initial assessment, including medication review
- Coordination of care across providers—for example, scheduling appointments, telephone consultations, reminders for screening, tests, etc.
- Care planning based on your needs, priorities, and preferences
- Coaching and monitoring of your health status

- Support and education
- Assistance with access to Kaiser Permanente and community resources

If you would like more information or help, you may call the self-referral phone line at **1-866-223-2347** (toll free).

Self-refer to our disease management program

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

Quality program information

At Kaiser Permanente, we are committed to providing quality, cost effective health care 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 method for comparing our performance to other health plans in the region.

The quality reporting that we participate with includes:

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

- National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction¹ which transitions to Health Equity in 2024²

Kaiser Permanente Commercial plans have a status of Accredited from the NCQA through 2024 ([ncqa.org](https://www.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.³ Kaiser Permanente's Medicare health plans are rated 4.5 out of 5 by the NCQA, the highest rating in Maryland, Virginia, and Washington, DC.⁴

To see the complete report, visit [ncqa.org](https://www.ncqa.org).

To find out more about the quality program or request a copy of the quality program or information, including a report of our progress toward quality improvement goals, call Member Services or visit [kp.org/quality](https://www.kp.org/quality).

Utilization management/resource stewardship program

Quality and efficient care through resource stewardship

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

Commitment to quality and compliance

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

Utilization management at Kaiser Permanente

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

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

Accessibility is important for all members, including members with special needs. Kaiser Permanente staff have the ability to send and receive messages with deaf, hearing

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.

³ NCQA awards were not given or endorsed by Medicare. Official CMS Star Ratings can be found at www.medicare.gov. The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality.

⁴ NCQA Medicare Health Plan Ratings 2025.

impaired, or speech-impaired members through Member Services.

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

Medically appropriate care

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

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

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

Coverage for medically necessary care

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

Utilization management affirmative statement: Health plan staff and practitioners

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

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

Medicare Part D drug fraud

Medicare Part D fraud is the illegal misuse of Medicare prescription drug plans. This type of fraud occurs when a provider, pharmacist, or member uses deception, or makes false statements, to obtain benefits under Part D that the member would not otherwise be entitled to receive. Examples of Part D fraud include

- A married couple who ask the provider to write all prescriptions for one spouse, even though some of the medications may be taken by the other spouse, to help reach the threshold.

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

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

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, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides 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, braille and accessible electronic formats
- Provides 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, 4000 Garden City Drive, Hyattsville, MD 20785, 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>.

This notice is available at <https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆኑ ተገቢ የሆኑ ረዳት መርዳቻዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-777-7902** ይደውሉ (TTY: **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-777-7902** (TTY: **711**).

Bàsɔ̀̀ Wùdù (Bassa) Mbi sog: nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoj ni soj, nij ma kénjɛn yé, mbi éyem. Wo nàj **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, আপনি বিনামূল্যে, উপযুক্ত সহায়ক পরিষেবা ও সাহায্য সমেত ভাষা সহায়তা পরিষেবা পেতে পারেন। **1-800-777-7902** (TTY: **711**)-এ ফোন করুন।

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-777-7902** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-777-7902** (تلفن متنی): **(711)** تماس بگیرید.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenten mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-777-7902** an (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-800-777-7902** (TTY: **711**) પર કોલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale kreyòl, w ap jwenn sèvis asistans lang tankou èd ak sèvis konplemantè adapte gratis. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएं मुफ्त उपलब्ध हैं। **1-800-777-7902** पर कॉल करें (TTY: **711**).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ ụnyere udi enyemaka na ọrụ kwesịrị ekwesị, n'efu, dị nye gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE. Se parla italiano, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-777-7902** までお電話ください (TTY: **711**)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-777-7902** 로 전화해 주세요 (TTY: **711**).

Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN: Díí saad bee yánítí'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aaah t'aala'l bí'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, kojí' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اردو (Urdu) توجه: اگر آپ اردو بولتے ہیں تو آپ مفت زبان کی معاونت کی خدمات حاصل کر سکتے ہیں، جیسے مناسب معاون امداد اور خدمات۔ کال کریں **1-800-777-7902** (TTY: **711**)۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Yorùbá, àwọn isẹ̀ irànlọ̀wọ̀ èdè tó fi kún àwọn ohun èlò irànlọ̀wọ̀ tó yẹ àti àwọn isẹ̀ láísí idíyelé wà fún ọ. Pe **1-800-777-7902** (TTY: **711**).

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