Being an informed Kaiser Permanente member

Information to know before, at, and after enrollment
Availability of services
Certain services are only available when you receive care at Kaiser Permanente facilities.

Prevention
Do you know at what age you should start colorectal cancer screenings? Or how often you should have a Pap test? Screening tests and immunizations help you get and stay healthy. 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
- health habits, and
- personal health history.

We have developed evidence-based guidelines for adults starting at age 18. They support health screening recommendations from organizations such as the Centers for Disease Control and Prevention. Find out what screenings you need at every stage of life online at kp.org/prevention. We also recommend that you sign up for kp.org and, once registered, that you complete the online total health assessment at kp.org/tha. This will give you a prevention plan that meets your needs and addresses what matters to you. You will also find other tools and resources there.

Advance directives: What you should know
Everyone has the right to make personal decisions about health care. But what if you can no longer make your own decisions? An advance directive allows you to designate a health care agent, someone you trust to make health care decisions for you if you are unable to do so yourself. An advance directive can also document your wishes concerning medical treatments at the end of life. While no one is required to have an advance directive, it is advisable to think ahead and make a plan.

You do not need a lawyer to fill out an advance directive. Your advance directive allows you to designate a health care agent, someone you trust to make health care decisions for you if you are unable to do so yourself. An advance directive can also document your wishes concerning medical treatments at the end of life. While no one is required to have an advance directive, it is advisable to think ahead and make a plan.

You do not need a lawyer to fill out an advance directive. Your advance directive becomes legally valid as soon as you sign it in front of the required witnesses. The laws governing advance directives vary from state to state, so it is important to complete and sign advance directives that comply with your state’s law. An advance directive from one state does not always work in another state. If you spend a significant amount of time in more than one state, you should complete an advance directive for each state in which you spend time.

Before an advance directive can guide medical decision making, two physicians must certify that you are unable to make medical decisions on your own. Advance directives do not expire. An advance directive remains in effect until you change it. If you complete a new advance directive, it invalidates the previous one.

You should review your advance directive periodically to ensure that it still reflects your wishes. If you want to change anything in an advance directive once you have completed it, you should complete a whole new document. You need to share your advance directive with your loved ones and your health care providers to ensure that your wishes are known.

Make several photocopies of your advance directive. Keep the original document in a safe but easily accessible place, and tell others where you put it. Give photocopies to your health care agent, your doctor, and anyone else who might be involved with your health care.

For more information about advance directives or to get your state’s form, contact:
- Caring Connections, 800-658-8898, or caringinfo.org
- Aging with Dignity, 888-594-7437, or agingwithdignity.org

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 plan 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 301-321-5126 or 866-223-2347 (toll free). You will be prompted to state your name, phone number, and medical record number, along with your reason for requesting a case manager. You will be called back within two business days to begin the assessment process.

Referrals to specialists
Kaiser 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. 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 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 at no charge) used in any decision regarding your care, please contact Member Services.

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 behavioral health or chemical dependency services (call the Behavioral Health Access Unit toll-free at 866-530-8778), and/or
- for dental services, only if you are a member who has purchased a
Choosing your prescription drugs

You and your Kaiser Permanente doctor should choose the prescription drugs that are best for you. Your Kaiser Permanente doctors and pharmacists will answer any questions about your drugs and will make sure you will be on the safest and most effective drugs for your needs. Kaiser Permanente has a drug formulary, or a list of preferred drugs, medical accessories, and supplies, to help doctors pick the drugs that will work best for you. 

Before including a drug in the Kaiser Permanente drug formulary, Kaiser Permanente doctors and pharmacists complete 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 or similarly);
- side effects; and
- interactions with other drugs

The drug formulary includes the drugs, accessories, and supplies that have been reviewed and approved for use by Kaiser Permanente doctors and Kaiser Permanente network doctors. Decisions about drugs on the formulary represent the clinical judgment and expertise of many doctors, pharmacists, and other health care specialists on our Kaiser Permanente Pharmacy and Therapeutics Committee. This Committee selects the drugs that are most appropriate for patient care. The Kaiser Permanente drug formulary includes brand-name 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. When the safety, effectiveness, and side effects of two or more drugs are the same, the cost of the drug would be considered when deciding whether to add the drug to the Kaiser Permanente drug formulary. 

If you think you need a drug that is not on the drug formulary, speak with your personal doctor. The non-formulary exception process is in place to give patients and doctors access to a medically necessary drug under the drug benefit, even when that drug is not on the drug formulary. Non-formulary drugs are covered by your drug benefit plan only if your doctor requests an exception to the formulary and provides documentation that the non-formulary drug is medically necessary for your treatment and that no formulary drug is suitable for you. Unless the criteria for a drug formulary exception are met, you will be required to pay full price (not just your prescription drug copay) for a non-formulary drug. You may request consideration of the non-formulary exception process by contacting your doctor or Kaiser Permanente Member Services at 800-777-7902 via telephone or email through kp.org. When doctors prescribe a non-formulary drug, the Kaiser Permanente Pharmacy and Therapeutics Committee makes note of the doctor’s drug formulary exception requests.

The Kaiser Permanente Pharmacy and Therapeutics Committee periodically reviews the non-formulary drugs prescribed to see if they should be added to the drug formulary. Kaiser Permanente doctors and members may also request that a non-formulary drug be added to the drug formulary by filling out the request form (for addition to or deletion from the drug formulary) available on kp.org or by calling Kaiser Permanente Member Services at 800-777-7902.

The cost of drugs, accessories, or supplies may vary depending upon the type of drug, accessory, or supply and your particular pharmacy drug benefit. Details about your pharmacy 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 insurance plan’s prescription drug benefit. 

You can find the drug formulary online at kp.org, or you can request a copy of the drug formulary by contacting Kaiser Permanente Member Services at 800-777-7902.

*Note: the KPMAS non-formulary exception process does not apply to those who purchased a health benefit plan through a public exchange or marketplace. For those members, any non-formulary or non-preferred drug will be approved without medical necessity and the copayment will be determined based on the medication tier and on your copay or coinsurance as defined in your coverage document, Membership Agreement, or Evidence of Coverage, respectively.

Marketplaces, sometimes called “exchanges,” are state or federally run places where people can buy health care coverage. They include websites, call centers, and physical locations, so you can get coverage online, over the phone, or in person. You can compare and choose health plans offered by private companies, get answers to questions, and find out if you are eligible for financial assistance or special programs. Marketplaces will also operate a Small Business Health Options Program (SHOP). There, small-business employers can purchase coverage for their employees.
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 EZ Refill Line. Ideal for routine (maintenance) drugs, this service allows you to phone, fax, or mail in your order. The EZ Refill Line also allows you to find out when your prescription drug refills are ready.

For the fastest service, call 800-700-1479, any time of the day or night (TTY 711, Monday-Friday, 8 a.m. to 7 p.m.) and follow the instructions. Select the “EZ Refill by mail” option to have your refillable prescription drug mailed anywhere in the United States 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 prescription drug at any pharmacy in our medical office buildings.

You may be able to receive additional savings when you use the “EZ Refill by mail” option. Refer to your contract for complete details about the drug benefits and services available to you.

Online prescription drug refills
For your convenience, you may also order your refillable prescription drugs online at kp.org.

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 at 800-777-7902. 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

- Maryland, go to www.mbp.state.md.us
- Virginia, go to vahealthprovider.com
- Washington, D.C., go to http://164.82.148.59/Physician%20Profile%20Lookup/Search.aspx

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 one of the 24 specialty boards accredited by the American Board of Medical Specialties, visit www.abms.org. Ninety-five percent 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: www.jointcommission.org/QualityCheck
- Maryland Health Care Commission: mhcc.maryland.gov
- Virginia Health Information: vhi.org
- Official 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, Virginia Hospital Center, and the 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.

How Kaiser Permanente physicians are paid

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<th>Definitions of how health plans may pay physicians for your health care services, with a simple example of how each payment mechanism works.</th>
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<td>The example shows how Dr. Jones, an obstetrician/gynecologist, would be compensated under each method of payment.</td>
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<tr>
<td><strong>Salary 0%</strong></td>
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<td><strong>Capitation 6.1%</strong></td>
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<td><strong>Fee-for-Service 0%</strong></td>
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<td><strong>Discounted Fee-for-Service 93.9%</strong></td>
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<td><strong>Bonus 0%</strong></td>
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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 providers depending on their 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, PC (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

These arrangements are the result of an agreement between 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.

You can also write to us:
Kaiser Permanente Member Services
2101 East Jefferson Street
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.

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 or not a new drug, procedure, or device is medically necessary and appropriate, our Technology Review and Implementation Committee, in collaboration with the Interregional New Technologies Committee and The Permanente Medical Group (TPMG) Medical Technology Committee, provides answers to critical questions regarding the indications for use, safety, effectiveness, and relevance of new and emerging technologies.

These interdisciplinary committees and the technology assessment unit are primary sources of information about the new medical technologies or new uses of existing technology. Various health care professionals, including primary care physicians, specialists, ethicists, research analysts, and managers, serve on the committees. The committees and the national technology assessment unit have access to subject matter experts, peer-reviewed literature, and technology assessments from within Kaiser Permanente and also from sources external to Kaiser Permanente, such as academic institutions and commercial technology assessment entities. If compelling scientific evidence is found that a new technology is comparable to the safety and effectiveness of currently available drugs, procedures, or devices, the committees may recommend that the new technology be implemented internally by Kaiser Permanente and/or authorized for coverage from external sources of care for its indication(s) for use. This technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

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

The P&T committee may evaluate or reevaluate any drugs approved by the Food and Drug Administration. 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; or
- lacks sufficient peer-reviewed clinical evidence to support safety and effectiveness for its intended use.

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

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 or contract.

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 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 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. MAPMG 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. We may collect information

• 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; and
• 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.
• 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.

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 require 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, emergency medical personnel, peer review committees, public licensing agencies, and private accrediting bodies.
• Information may be shared with other companies that perform services on our behalf to develop and mail information to our customers about products and services.

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

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

We recently 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 include

• expanded definition of 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

Download the latest Notice at kp.org/privacy. If you have questions or want to request a printed copy, call our Member Service Contact Center at 800-464-4000, 24 hours a day, seven days a week (closed holidays), or for TTY for the deaf, hard of hearing, or speech impaired, call 711.

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

Kaiser Foundation Health Plan, Inc., subsidiaries, and affiliated entities
Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Health Plan of Colorado
Kaiser Foundation Health Plan of Georgia, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Foundation Health Plan of the Northwest
1800 Harrison Foundation
Camp Bowie Service Center
Kaiser Health Alternatives
Kaiser Health Plan Asset Management, Inc.
Kaiser Permanente Insurance Company
Kaiser Properties Services, Inc.
KP Cal, LLC
Lokahi Assurance, Ltd.
Oak Tree Assurance, Ltd.
OHP
Ordway Indemnity, Ltd.
Ordway International, Ltd.
Rainbow Dialysis, LLC

Kaiser Foundation Hospitals, subsidiaries, and affiliated entities
Kaiser Foundation Hospitals
HAMI–Colorado, LLC
Kaiser Hospital Asset Management, Inc.
Kaiser Permanente International
KP OnCall, LLC
Kaiser Permanente Ventures, LLC
Kaiser Hospital Assistance Corporation
Kaiser Hospital Assistance I, LLC
NXT Capital Senior Loan Fund I, LLC

The Permanente Federation and affiliated entities
The Permanente Federation, LLC
Colorado Permanente Medical Group, P.C.
Hawaii Permanente Medical Group, Inc.
Mid-Atlantic Permanente Medical Group, P.C.
Northwest Permanente P.C., Physicians and Surgeons
Permanente Dental Associates, P.C.
Southern California Permanente Medical Group
The Permanente Medical Group, Inc.
The Southeast Permanente Medical Group, Inc.
Group Health Permanente, P.C.

Member complaint procedures
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. And you always have the right to file a compliment or complaint with Kaiser Permanente.

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
Correspondence Unit
2101 East Jefferson Street
Rockville, MD 20852

All complaints are investigated and resolved by a Member Services representative by coordinating with the appropriate departments. 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.

How to file an urgent or nonurgent appeal
Expedited appeals are available for medically urgent situations. In these cases, call Member Services at 800-777-7902.

After business hours, call an advice nurse
- within the Washington, D.C. metro area, 703-359-7878 (TTY 711)
or
- outside the Washington, D.C. metro area, toll free at 800-777-7904 (TTY 711).

Appeals for nonurgent services must be submitted in writing. When doing so, please include
- the member’s name and medical record number,
- a description of the service or claim that was denied,
- why you believe the health plan should authorize the service or pay the claim, and
- a copy of the denial notice you received.

Send your appeal to
Kaiser Permanente Member Services
Appeals Unit
2101 E. Jefferson St.
Rockville, MD 20852

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, conduct research, and prepare your request for review by the appeals/grievances committee. The analyst will also inform you of the health plan’s decision regarding your appeal/grievance request along with 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 contact one of the following agencies:

IN MARYLAND
- Office of the Attorney General
  Consumer Protection Division
  Health Education and Advocacy Unit
  200 St. Paul Place
  Baltimore, MD 21202
  877-261-8807 (toll free)
  Web: www.oag.state.md.us
  www.oag.state.md.us/Consumer/HEAU.htm

- Maryland Insurance Administration
  Appeals and Grievance Unit
  200 St. 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)
  Web: www.scc.virginia.gov/boi/omb
  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
  800-552-7945 (toll free)
  TDD 804-371-9206
  Web: scc.virginia.gov/boi/co/health/index.aspx
- 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: www.vdh.state.va.us/olc
  Email: mchip@vdh.virginia.gov

IN THE DISTRICT OF COLUMBIA
- Department of Health Care Finance
  Office of the Health Care Ombudsman
  and Bill of Rights
  899 N. Capitol St. NE
  6th Floor
  Washington, DC 20002
  202-724-7491
  202-535-1216 (fax)
  Web: www.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: opm.gov

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:

1. Actively participate in discussions and decisions regarding your health care options.
2. 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.
3. Receive relevant information and education that helps promote your safety in the course of treatment.
4. 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.
5. Refuse treatment, provided that you accept the responsibility for and consequences of your decision.
6. Give someone you trust the legal authority to make decisions for you if 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.
7. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
8. 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.
9. 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. Your 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 who 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 acknowledgment and a resolution in a timely manner.

h. Receive information in languages other than English, in large print, or other alternative formats.

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.

Contact us
Appointments and 24-hour medical advice
You can call to make routine appointments Monday through Friday, 7:30 a.m. to 8 p.m., and Saturday, Sunday, and holidays from 7:30 a.m. to 11:30 a.m. Medical advice is also available 24 hours a day, seven days a week from medical advice nurses.

For either of these services, call one of the following numbers

In the District of Columbia metro area
703-359-7878 (TTY 711)

Outside the Washington, D.C. metro area, call toll free
800-777-7904 (TTY 711)

If you see a physician who does not practice in one of our medical centers, call your physician’s office first. If no one is available to assist you, call our 24-hour medical advice line.
If you would like to leave a nonurgent message for a medical advice nurse, registered users can do so at kp.org; you will receive an answer within one business day.

If your primary care doctor is a Mid-Atlantic Permanente Medical Group Professional Corporation (MAPMG, P.C.) Affiliate, call your doctor first. If no one is available to assist you, call our 24-hour medical advice line.

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.

Quality program information
At Kaiser Permanente, we are committed to providing quality, cost-effective health care. Our physicians and managers work together to improve care, service, and the overall performance of our organization. We participate in a number of independent reports on quality of care and service so that you have reliable information about the quality of care we deliver, as well as a method for comparing our performance to other health plans in the region.

The quality reporting that we participate with includes:
- 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, and
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure health plan member satisfaction.

Kaiser Permanente has been awarded an “Excellent Accreditation” from 2004 to 2016 from the National Committee for Quality Assurance (NCQA), the highest award given for service and clinical quality. This award is given only to organizations that meet or exceed NCQA’s rigorous requirements for consumer protection and quality improvement. To see the complete report, visit ncpa.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 800-777-7902.

Utilization management/resource stewardship program
Quality and efficient care through resource stewardship
To ensure that we are good resource stewards, we have several programs designed to review and continuously improve our systems and the quality of care and service members receive.

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.

Resource stewardship at Kaiser Permanente
Personal physicians provide and coordinate members’ timely and medically appropriate care. Resource stewardship 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 rendered. Resource stewardship 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/utilization management (UM) program, contact a Member Services representative, who can give you information about the status of a referral or an authorization; give you a copy of our criteria, guidelines, or protocols (at no charge) used for decision making; answer your questions about a denial decision; or connect you with a member of the resource stewardship/ utilization management team. You may reach UM staff by calling Member Services at the number on back of your Kaiser Permanente ID card. Staff identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

Accessibility is important for all members, including members with special needs. Kaiser Permanente staff have the ability to send and receive messages with deaf, hard of hearing, 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. Utilization management 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 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, as that 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 or Certificate of Insurance for details regarding your appeal rights.

**Utilization management affirmation statement: Health plan staff and practitioners**
The staff of the health plan, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., administers benefits, ensures compliance with laws and regulations, screens for quality of care, reviews how care and services are used, arranges for your ongoing care, and helps 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. Kaiser Permanente 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.

**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. As part of a national health care organization, our care management program gathers the most successful clinical methods developed by our physicians and combines them with the latest in medical research. The care management program then works with each Kaiser Permanente region in the country to apply that knowledge to patient care. The care management program also offers information on evidence-based, modern medical treatments to support our physicians in managing and preventing the complications of such chronic illnesses as diabetes, asthma, high blood pressure, 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.

**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. Leave a message anytime at 703-536-1465 in the Washington, D.C. metropolitan calling area or 410-933-7739 in the Baltimore area. Please leave your name, medical record number, address confirmation, and the condition for which you are requesting information.