KAISER PERMANENTE®

Frequently asked questions about Kaiser Permanente

www.kp.org

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
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KAISER PERMANENTE®

Total health is not just our business—it's our cause. At Kaiser Permanente we stand for health.

We understand that choosing a health plan is one of the most important decisions you can make for the life of your business or organization. The choice you make can be critical to your business' productivity and your employees' well being. That's why Kaiser Permanente delivers care that focuses as much on immunization and nutritional guidance as it does on chronic illness. We encourage members to be actively involved in their own health care, including learning about making healthy choices, managing chronic conditions and understanding how to prevent illness and disease.

We know that you are often faced with answering many questions about the health plans you offer to your employees. This brochure will help you to answer those questions as well as give you a better understanding of how we help ensure the total health of your employees and your organization.

The organization

Q: How do you deliver health care?

A: Health care is provided to members by the physicians of the Mid-Atlantic Permanente Medical Group (MAPMG) who practice in our 28 medical centers. Care is also provided in private doctor's offices in the community, through our affiliated network of physicians. Additionally, care is provided through any licensed provider who practices outside our network.

Depending on the product you choose, the care delivery methods are provided through either a group model health maintenance organization (HMO), a network HMO health plan option and now a PPO network.

Q: Describe your group model HMO and network HMO health plan.

A: Kaiser Permanente Signature℠ is our group model HMO health plan. When care is provided exclusively by the MAPMG physicians who practice in our medical centers, it is delivered through Kaiser Permanente Signature. Through this health plan, each member chooses a primary care physician (PCP) who arranges and coordinates primary, specialty, and hospital care. In most cases, Kaiser Permanente Signature members who require hospital services receive treatment at one of our primary hospitals, but MAPMG physicians may refer members to other hospitals as appropriate.

Founded in 1945 as a not-for-profit, group-practice prepayment program, Kaiser Permanente serves the health care needs of 8.2 million members in nine states and the District of Columbia, including California, Colorado, Georgia, Maryland, Ohio, Oregon, Virginia, and Washington. Today, the organization encompasses Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals and their subsidiaries, and the Permanente Medical Groups. We also partner with Group Health Cooperative in Seattle, AvMed Health Plan in Florida, and Sierra Health Services in Texas. We are headquartered in Oakland, California, and our 2003 revenues were $25.3 billion.

Nationwide, the Kaiser Foundation employs approximately 135,000 technical, administrative, and clerical staff and the Permanente Medical Group employs approximately 11,000 physicians representing

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When members receive care from physicians in our network, it is delivered through our network HMO health plan, Kaiser Permanente Select℠. Through this plan, in addition to being able to choose a MAPMG physician who practices in our 28 medical centers, members can also choose from our network of more than 8,900 physicians in private practice in the community. Members also have access to a wide range of hospitals within our region.

With both of these plans, employers can add on the option that allows members to receive care from any licensed provider who practices outside of our network. This is our point-of-service plan option, Kaiser Permanente Added Choice℠. Employers who offer Added Choice may incur lower total health care costs than with traditional indemnity plans, while providing their employees with the benefits of an HMO.

If you have employees who live and work outside of our service area, care is provided by physicians who are not part of our network, through our out-of-area plan, Kaiser Permanente Out-of-Area PPO. This plan is an indemnity option offered by Kaiser Permanente Insurance Company and provides members who live and work outside of the Mid-Atlantic States service area with the ability to receive care. This out-of-area plan covers both participating, in-network providers as well as nonparticipating, out-of-network providers. With this plan, members also incur reasonable out-of-pocket expenses for providers outside of our service area.

Q: Have you made any changes to your product portfolio?

A: In 2003, we expanded our product offerings to include more than 14,000 physicians and other health care professionals from a national PPO network. These additional physicians are available to our members through our new health plan product, Kaiser Permanente Flexible Choice.

Q: How does Kaiser Permanente Flexible Choice work?

A: Kaiser Permanente Flexible Choice offers members three provider options.

Option 1 of Kaiser Permanente Flexible Choice is our traditional HMO model, which will allow your employees to choose any physician practicing in our 28 medical centers and affiliated community-based providers. This option carries the lowest out-of-pocket costs.

Option 2 is our national PPO network that includes approximately 14,000 physicians and other health care professionals who are part of the CCN national PPO network. This option requires members to meet annual deductibles and pay copayments and/or coinsurance.

Option 3 is our Out-of-Network Provider option, allowing your employees to choose any licensed provider not already identified in Options 1 and 2. This option requires members to meet higher annual deductibles plus pay higher coinsurance amounts.

Q: Do you provide coverage for Medicare-eligible seniors?

A: We offer a Medicare Cost HMO plan that provides Medicare beneficiaries access to providers in MAPMG. Unlike traditional Medicare and many Medicare gap policies, this plan, which is named Kaiser Permanente Medicare Plus℠, provides pharmaceutical, optical, and dental care.

With Kaiser Permanente Medicare Plus, members receive state-mandated benefits in addition to their Medicare benefits. Medicare Plus members receive all in-network care from MAPMG contracted providers (except for emergency or out-of-area urgently needed care) but will also be able to choose a doctor outside our network who accepts Medicare. Although we will not reimburse members for services received outside our network (except for emergency or out-of-area urgently needed care), members may submit the claim to Medicare, which will pay its share of approved charges. The members' original Medicare deductibles and coinsurance will apply. This arrangement provides more flexibility for members who travel outside our service area.

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all specialties. We operate 430 medical offices and medical centers throughout the country where our members receive care.

Members may receive services at any Kaiser Permanente medical office or medical center nationwide. This means that Kaiser Permanente members have broad coverage, even when away from the Mid-Atlantic States service area.

Kaiser Permanente members receive the following benefits:

- outpatient care including outpatient surgery
- extensive inpatient hospital services
- skilled nursing care
- maternity care
- vision care
- rehabilitation services
- ambulance services

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Q: What is the organization's full legal name? How is the organization operated?

A: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is the legal name of our health maintenance organization. We operate under the trade name "Kaiser Permanente" and are a subsidiary of a national organization named Kaiser Foundation Health Plan, Inc. We are a nonprofit organization exempt from federal taxation under section 501(c)(3) of the Internal Revenue Code.

Kaiser Permanente is an integrated, jointly operated medical care program that combines the power of the health plan and the Mid-Atlantic Permanente Medical Group, P.C.

The Mid-Atlantic Permanente Medical Group (MAPMG) is a multispecialty physician group practice whose physicians provide health care exclusively for Kaiser Permanente members. MAPMG physicians practice in our 28 medical centers and various other care facilities including behavioral health, imaging centers, and area hospitals.

As independent organizations, both the health plan and MAPMG maintain separate governing bodies and management. Senior managers from both organizations serve together on a number of joint committees, including the following:

- the quality assurance/quality improvement committee, which monitors quality assurance and utilization activities
- the new technologies committee, which evaluates new medical technologies and drugs
- the ethics committee
- the claims appeals committee

Physicians and hospitals

Q: Can prospective members and existing members access your list of physicians online?

A: Yes, members can find our list of physicians on our public Web site, *www.kaiserpermente.org*. They can view an electronic version of the printed directory of physicians, seeing each page as it appears in the book.

They can also use our online search engine to find a doctor. With just a few clicks of the mouse, members can find physicians in a particular county, city, state, or zip code. They can search for physicians by specialty, medical center or product plan. Once the results of this online search are produced, members can click on the physician's name and get additional information about that physician.

Members can also find our list of hospitals, behavioral health services, and locations, as well as specialty care centers.

Q: Can members self refer for specialty care?

A: Members can self refer for behavioral health, obstetric/gynecological, and vision care services. They must, however, receive a referral from their PCP for other specialty services except under certain circumstances, such as treatment that requires and falls under "standing referrals." Employers who purchase a Kaiser Permanente dental rider benefit can self refer for those services as well.

Primary care physicians coordinate their patients' timely and medically appropriate care. They authorize and make referrals for most other covered specialty care and all hospital services. Medically appropriate care is care that is necessary for the diagnosis, treatment, and/or management of a medical condition within accepted standards of medical care and performed in a capable setting at the precise time required to treat the patient. Physicians, in consultation with their patients, make all decisions regarding medical appropriateness.

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- durable medical equipment (DME)
- organ transplant services
- home health care
- behavioral health/ substance abuse services (inpatient and outpatient)
- infertility services
- urgent and emergency care

Please note that this is a general list and does not cover all available benefits and services. Kaiser Permanente would be pleased to quote a full benefit package upon request.

Groups can select from an array of additional benefits to fit their specific group needs. These benefit options include, but are not limited to, prescription drug, dental services, and alternative medical services such as acupuncture and biofeedback. Our Complementary

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Q: How many physicians have open panels?

A: All of our MAPMG physicians have open panels with the exception of those primary care physicians who are scheduled to leave Kaiser Permanente, are not renewing their contracts with us, or are taking an extended leave from actively seeing members (i.e., on sabbatical, maternity leave, etc.). This means that your employees have a wide selection of physicians from which to choose a personal physician. In 2003, we also implemented a new process to help ensure that patients see their primary care physician when they make their appointments.

Members can make appointments in advance by calling or going online through *www.members.kp.org*. They can also get appointments for the same day they call, when time is available in their doctor's schedule.

Q: Does a member get to choose his or her own primary care physician at open enrollment?

A: Yes. We encourage members to choose their own primary care physician when they initially enroll in the plan. In the event that a member does not select a personal physician, we will assign the member to the nearest Kaiser Permanente physician based on the member's residential zip code. Members are free to change their personal physician at any time, for any reason, and may contact our Member Services department for additional information about available physicians or to receive assistance with the selection process.

Q: What are your credentialing criteria for physicians?

A: During our physician selection/credentialing process, we use primary verification to check the following items required by regulatory bodies, including the National Committee on Quality Assurance (NCQA):

- graduation or completion of residency from a U.S. accredited college of medicine (essential for board certification)
- valid state license (for state of practice)
- board certification/eligibility appropriate to practice area
- federal and state DEA controlled substance registration and unrestricted prescribing privileges
- all admitting privileges at network hospitals

- adequate malpractice coverage
- detailed malpractice history for last 10 years
- detailed history of disciplinary action or litigation
- National Practitioner Data Bank entries
- Medicare/Medicaid sanctions
- completion of residency
- detailed history of general health
- detailed history of chemical dependency
- detailed history of behavioral health
- detailed history of conviction for fraud or felony

We recredential all providers at least once every two years from the date of their initial appointment. Our recredentialing criteria are similar to those for initial credentialing and may include

- pharmacy utilization
- HEDIS prevention measures
- adherence to clinical guidelines
- site visits
- randomized medical chart review
- member complaints/grievances
- member satisfaction surveys

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Alternative Medicine (CAM) rider provides benefits focused on a broad range of healing philosophies, approaches, and therapies; these alternative methods include chiropractic care, herbal medicines, acupuncture, and nutritional guidance.

Kaiser Permanente provides a range of services that support medical care. They include:

- self-care and wellness services featuring health education materials and classes
- a members-only Web site, at *www.members.kp.org*, where members can receive information on nonurgent health matters, obtain nonurgent care appointments, access medical and drug encyclopedias, find links to other health and medical Web sites, and more

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All MAPMG physicians must be board certified or board eligible when we hire or contract with them. Board-eligible physicians must obtain board certification within four years of hire to continue practicing with MAPMG and providing care to Kaiser Permanente members.

Q: Do you have network physicians in the Washington/Baltimore area?

A: Yes. In order to provide our members with added convenience, we have joined with networks of affiliated providers in Maryland and the District of Columbia. Specifically, we are affiliated with the George Washington University Medical Faculty Associates in Washington, DC.

Members who live in Maryland and choose our Annapolis Medical Center also have access to the Potomac Physicians Network, while members who choose our Columbia Gateway Medical Center also have access to physicians in private practice throughout Howard County. In Baltimore, we are affiliated with the Johns Hopkins Community Physicians Network.

Q: How do you reimburse your physicians? Do you use incentives to encourage proper utilization?

A: Kaiser Permanente compensates MAPMG through a global capitation payment arrangement. We calculate our primary compensation for MAPMG according to total forecast membership; the payment does not vary with the volume of physician services.

Physicians may receive additional compensation if Kaiser Permanente meets or exceeds the following targets:

- quality of care
- patient satisfaction
- operating net income goals

We reimburse community PCPs through capitated arrangements and reimburse fee-for-service and specialist services through discounted RBRVS, capitation, and some case rates.

Q: How do members access behavioral health or chemical dependency services?

A: Members with behavioral health benefits may self refer for behavioral health or chemical dependency services by calling our Behavioral Health Access Unit telephone number. They may also request a referral from their PCP.

In Washington, DC, Virginia, and Maryland, including Baltimore, we provide services through the MAPMG Behavioral Health Integrated Delivery System, accessible toll free, at 1-866-530-8778 and at the following medical centers:

- Merrifield (Virginia)
- West End (District of Columbia)
- Marlow Heights (Maryland)
- Summit (Maryland)
- Woodbridge (Virginia)—some chemical dependency and psychiatric services

Our Web site, *www.kaiserpermanente.org*, lists all of the ways and locations to receive behavioral health and chemical dependency care.

Q: What hospitals do you use?

A: We contract with many area hospitals including Holy Cross Hospital, Inova Fairfax and Fair Oaks Hospitals, Johns Hopkins Hospital, National Children's Medical Center, Anne Arundel Medical Center, and Howard County General Hospital. Our Web site, *www.kp.org*, has a complete list of our contracted hospitals. In order to deliver continous care to our members, we have core hospitals where we have physicians, hospitalists, and other health care professionals on staff and dedicated to providing care specifically for Kaiser Permanente members.

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- case management services, managed by Kaiser Permanente, (except in Baltimore) for hospitalized patients that include post-hospital and follow-up care
- ambulatory case management services to help members with certain chronic conditions learn to control and manage their illness
- disease management programs developed by Kaiser Permanente for members diagnosed with specific chronic conditions
- behavioral health and chemical dependency services, where members receive care through our integrated behavioral health delivery system, comprised of MAPMG behavioral health practitioners and a selected network of community affiliates working together to provide quality care and services

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Q: How do you select hospitals for your network?

A: We only contract with licensed, JCAHO-accredited facilities that can offer the full range of hospital services necessary to meet our patients' needs. Before contracting with a hospital, we review the following items:

- JCAHO accreditation
- Medicare certification
- malpractice history
- peer review proceedings
- financial stability
- state licensure
- clinical outcomes
- infection rates
- mortality and morbidity rates

We also consider each hospital's range of services, community reputation, ability to meet performance standards for quality improvement initiatives, financial stability and efficiencies, and administrative support systems' ability to respond to patients' needs.

Quality Care

Q: Are you accredited by NCQA?

A: NCQA has awarded its highest accreditation status of Excellent to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for service and clinical quality that meet or exceeds NCQA's rigorous requirements for consumer protection and quality improvement. HEDIS results are in the highest range of national performance.

This accreditation is effective for three years, beginning June 15, 2004. Strengths cited by NCQA include:

- Demonstrated organizational commitment to the delivery of quality care and service
- Demonstrated dedication to providing culturally competent care
- Strong emphasis on the use of electronic technology
- Effective Quality Improvement program
- Collaborative relationship with Kaiser Permanente Care Management Institute to implement disease management programs

Q: Do you have programs that focus on patient safety?

A: Patient safety has always been a central focus of our quality program and we are committed to becoming a national leader in patient safety. Through our patient safety and medication safety committees, we develop initiatives and monitor their success across the region. In one recent initiative, we are looking into ways to reduce the potential for medication errors through numerous medication safety processes. We regularly update our members about patient safety topics through our member newsletter, *Partners in Health*.

Q: Describe a care management program. How do you target members for the programs?

A: Keeping patients healthy is the focus of our care management programs. Kaiser Permanente developed the national Care Management Institute (CMI) to keep members who suffer from chronic conditions healthy. CMI draws upon Kaiser Permanente's internal clinical experts and existing efforts in best practice transfer, implementation, epidemiological research, outcome measurement, guidelines development, and care redesign. The institute also conducts primary research on health care provider behavior changes to improve the speed and effectiveness of implementation.

In our care management programs, we focus on diseases or health conditions that show evidence that a coordinated, intense effort can make a difference in a member's health. Once we identify members for the programs, we rank the members in logical groupings according to risk of complications for triage purposes.

For instance, if a member understands his or her disease, is managing it well, and tests show few or no problems, we may focus on positive reinforcement and periodic assessment. If the member is not managing the disease well and screening tests are showing pre-symptomatic problems, then we may use patient education and counseling to reduce the patient's risk. If the member is beginning to have complications from the disease, we may provide more intense case management and specialty medical care, as needed.

In all cases, the use of evidence-based periodic screening, assessment, and treatment of the total grouping is imperative. Primary care physicians receive periodic reports on the status of their patients in each targeted grouping and maintain principal responsibility for each member's treatment and coordination of services.

In the Mid-Atlantic Region, a disease manager and physician lead are responsible for the overall coordination of each targeted disease. The targeted diseases/health status include the following:

- asthma
- diabetes
- heart failure (HF)
- coronary artery disease (CAD)
- renal disease management
- Tender Loving Care (TLC) program
- depression
- elder care
- hypertension

We conduct monthly reviews of the following computerized records to identify members to enroll in one or more of our care management programs:

- pharmacy utilization
- emergency room visits/admissions
- inpatient admissions

Members are informed through regular mailings and newsletters.

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Many Kaiser Permanente members choose a personal physician from the Mid-Atlantic Permanente Medical Group (MAPMG), who practice exclusively in our 28 multispecialty medical centers. Our medical centers offer both primary care and specialty care. Most of our medical centers also have onsite pharmacy, laboratory, radiology, and optical services.

All new subscribers receive a new member care package shortly after enrolling. This new member package contains a directory of physicians or a member handbook, information about how to access services, and a *HealthWise® Handbook*, that provides self-care information. Members can choose a primary care physician (PCP) from the directory when they enroll or contact the Member Services department for assistance. They can also access a directory online by visiting our Web site, *www.kp.org*.

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Pharmacies and prescriptions

Q: Where can patients fill prescriptions?

A: Ninety-six percent of our members' prescriptions are processed through pharmacies located in Kaiser Permanente medical centers. In addition, members can use the Kaiser Permanente mail-order pharmacy to refill most prescriptions (exceptions include all pharmaceuticals that require refrigeration, except insulin, all narcotics, and all over-the-counter medications). Refill requests can also be made online at *www.members.kaiserpermanente.org*.

Many Kaiser Permanente members also have the option to fill prescriptions at pharmacies that participate in our community network. There are more than 4,000 pharmacy sites throughout the region, both retail and independent, that participate in the network.

Participating major chains in the network include the following:

- Safeway
- Wal-Mart
- Giant
- Target
- Rite-Aid

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Members have the option to refill prescriptions through a variety of easy refill programs, including phone, online, fax, and mail.

Our pharmacy refill center mails orders within 24 hours of receipt of a refill request, with no additional shipping fee, anywhere in the U.S. (firstclass mail). While members generally can expect the refills to arrive within five business days, we advise members to order their refills when a two-week supply still remains. Members may also use the EZ Refill line to find out if their prescriptions are ready before making a trip to the medical center.

If a member's prescription runs out, the new electronic ordering system will immediately alert the member's physician of the refill request. Furthermore, because we operate EZ Refill, members are assured that they will receive the same personalized care they receive in our pharmacies.

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Q: Do you use an open or closed formulary?

A: We use an open and voluntary formulary consisting of preferred products. Preferred products include both generic, as well as a large number of brand-name drugs. Our Pharmacy and Therapeutics Committee approves our formulary, which contains drugs suggested for treatment of specific illnesses and conditions.

The Committee examines the following quality indicators when considering a drug for the formulary:

- side-effects profile: drugs with the fewest side effects receive more favorable recommendations;
- classification as a first, second, or third-line drug for use in the course of treatment;
- approval by Kaiser Permanente's national pharmaceutical committee;
- comparison with other drugs treating the same illnesses and conditions;
- cost: we are committed to providing safe, cost-effective medicine to our members; and
- formulary drugs meet Orange Book regulations issued by Maryland, Virginia, and the District of Columbia. Currently, the formulary consists of more than 1,500 formulations.

If a member requires a nonformulary drug because the member fails to respond to formulary drug therapy, or has special circumstances requiring the use of nonformulary medication, an exception process allows us to cover these medically necessary nonformulary drugs when physicians prescribe them.

Members can access our drug formulary online at *www.members.kaiserpermanente.org*.

Q: Can members request a brand-name drug over a generic drug?

A: Members may request and receive a nonformulary or brand-name drug anytime by paying the full price for the drug even if the member's physician does not deem it medically necessary.

E-communication and technology

Q: Do providers have access to electronic member records?

A: MAPMG providers currently use the Physician Access Care Enhancement (PACE) system, an electronic medical record system, to facilitate information management and communication. All authorized MAPMG physicians and staff located in Kaiser Permanente medical centers have access to PACE. Authorized physicians and staff not located within Kaiser Permanente Medical Centers can use PACE through remote access, such as at our main or core hospitals.

The PACE record includes the following:

- physician office visit notes and consultations
- calls to the medical advice nurses and health care team nurses
- pharmacy records
- laboratory tests results
- hospitalization and emergency room visit information
- referrals
- radiology test results
- case management notes
- record of appointments and provider schedules
- member demographics and benefits

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As a nonprofit organization, operating income generated by the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is available for reinvestment in facilities and systems and can finance charitable, educational, research, and other related programs. We are committed to providing a benefit to the communities in which we operate; for example, we provide ongoing access to primary care and preventive services for low-income people who do not meet requirements for government programs but do not have access to private health insurance.

Kaiser Permanente uses a cost-based adjusted community rating (CBACR) system, which uses actual group costs as one of the key inputs to derive rates rather than utilization statitics and factors. We update the underlying data on a monthly basis to

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Through PACE, an In-Basket Messaging System also allows case managers to communicate with physicians and other providers about services and care for individual members. The Consult and Referral Request Systems permit physicians and staff to enter directives electronically for internal and external services.

PACE also has a Face Sheet screen that includes information regarding medications, health conditions, allergies, past surgeries, health alerts, and historical information. To support patient confidentiality, PACE has an audit process that is useful in preserving the confidential nature of health care records.

PACE also has a reference library that contains approved clinical practice guidelines.

We integrate clinical and financial systems for plan decision-making. Integrated systems include clinical, laboratory, prescription, HEDIS, financial, hospital admissions, and ER visits. The data is available to providers, pharmacists, case managers, and vendors.

Q: What is Kaiser Permanente HealthConnect? Is it a new medical record system?

A: Kaiser Permanente HealthConnect is an integrated medical records system that will automate medical and patient information and place it at the fingertips of our medical professionals.

This means it combines electronic clinical records with appointments, registration, billing, and referrals to enhance our care delivery and operational efficiency across the Kaiser Permanente organization, including in such areas as claims and patient information and safety. By placing all of this medical and patient information at the fingertips of our health care professionals, it will revolutionize patient care delivery with some of the most advanced health care technology available.

As a result, Kaiser Permanente HealthConnect can directly affect your business by:

- Helping to increase your ability to make more informed and therefore better decisions about your health care offerings.
- Allowing Kaiser Permanente to be more productive and flexible in addressing your business needs as well as the health care needs of patients and caregivers.

Kaiser Permanente HealthConnect is an investment in the future of health care.

Q: Can members schedule appointments online?

A: Yes, our members are able to request a nonurgent appointment, receive advice from nurses and pharmacists, and choose or change their primary care physician. Members are also able to request ID cards, change personal contact information, complete health appraisals, research health encyclopedias, participate in professionally moderated discussion groups, and do many more activities.

Q: Do you offer customized Web pages to employer groups?

A: We offer group-specific Web pages to our large employer groups. Through this program, titled "Your Company Page," we provide group-specific benefits, standard information, and links to the *www.kaiserpermanente.org* Web site. There is no cost for the development of "Your Company Page."

We will develop "Your Company Page" as an online tool for employees to obtain their Kaiser Permanente benefit information. The pages reside on our national Web site.

Employer groups may have a link to this page placed on their Intranet site for easy access to our national Web site, which will provide contact names and numbers and other important information.

Through "Your Company Page" employers and their employees will be able to do the following:

- view their company-specific benefits and copay information
- download Kaiser Permanente enrollment forms and frequently asked questions
- access information about Kaiser Permanente's online resources
- access Kaiser Permanente national and members-only Web sites
- request a nonurgent appointment online
- access Member Services
- research health topics and learn about available health education classes

Your Account Manager will be happy to provide additional information regarding the development of "Your Company Page."

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give our customers the most current information. We are committed nationally to making final rates available as early as possible in the year. Moreover, we work with other Kaiser Permanente regions using CBACR to develop consistent renewal packets for our national accounts.

Claims

Q: Do you process claims in house?

A: We process most claims in house; for certain providers, we delegate claims processing to the provider.

Q: Please describe the steps patients are expected to take when filing a claim.

A: When members visit a physician who is in the Mid-Atlantic Permanente Medical Group or who is part of our affiliated network of community-based physicians, they do not have to file a claim form. However, if a member receives services from a physician who is not in our network or in our medical centers, the member mails the claim (or bill if the member was required to pay at the time of service) to the address listed on the back of their member ID card. For example, if an HMO member receives emergency or urgent care outside the delivery service system or a POS member exercises their out-of-plan benefits, the member would be required to file a claim.

Q: What can members do if they have questions about how to submit a bill or check on a claim they filed?

A: Members should call Member Services at (301) 468-6000, 1-800-777-7902 toll free, (301) 870-6380 TTY, from 7:30 a.m. to 5:30 p.m., Monday through Friday.

Q: Please describe your appeals process.

A: The appeals process begins when the member sends a written request to the Member Services department to appeal a denied claim in accordance with the guidelines specified in the regulatory requirements.

The standard appeal includes five steps:

(1) The member, provider, or member's authorized representative submits a request for a standard appeal.
(2) Kaiser Permanente researches the appeal.
(3) The case is reviewed for administrative approval.
(4) The case is then presented to the appeals/grievance committee, at which time the member/provider/authorized representative may participate in the presentation of the case to the committee.
(5) The decision to approve or deny the request is communicated to the member, provider, or authorized representative.

In Maryland, Virginia, and the District of Columbia, the member receives information relating to their rights for further review by external agencies along with the decision to approve or deny the request. Federal employees and retirees receive information regarding their rights for further review by the Office of Personnel Management. For Medicare members, we submit every denied appeal case for Medicare-covered benefits to Medicare's independent review agency for further consideration; the Medicare member does not need to request this further review.