KAISER PERMANENTE®

Individual and Family Plans

Core Bronze HSA AIAN

If you are American Indian or Alaska Native (AIAN), you may be eligible for this health plan. This plan features the Core network, which offers you access to specially selected providers for the greatest value. There is no cost sharing for items and services received through Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Effective Jan. 1, 2017. Available through Washington Healthplanfinder.

CALENDAR COSTS

Annual deductible	$5,500 Indiv / $11,000 Family
Coinsurance	20%
Out-of-pocket maximum	$6,550 Indiv / $13,100 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	20%
Prescription drugs Costs per 30-day supply	Generic: 20% Brand: 40% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: 15% Brand: 35% Specialty: 50%
Urgent care	20%
Hospitalization	20%
Emergency services	20%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 20%
Laboratory and radiology services	20%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	20%
Ambulatory outpatient services	20%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY** PCY = Per calendar year

This plan is only available to American Indians and Alaska natives who qualify. For more information, including premium rates, **visit wahealthplanfinder.org.**

PRIMARY CARE

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE

These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

*Nutrition counseling may be covered as preventive when certain requirements are met.

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington

KAISER PERMANENTE®

Individual and Family Plans

Core Silver HSA AIAN

If you are American Indian or Alaska Native (AIAN), you may be eligible for this health plan. This plan features the Core network, which offers you access to specially selected providers for the greatest value. There is no cost sharing for items and services received through Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Effective Jan. 1, 2017. Available through Washington Healthplanfinder.

CALENDAR COSTS

Annual deductible	$3,000 Indiv / $6,000 Family
Coinsurance	10%
Out-of-pocket maximum	$5,750 Indiv / $11,500 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	10%
Prescription drugs Costs per 30-day supply	Generic: 10% Brand: 30% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: 5% Brand: 25% Specialty: 50%
Urgent care	10%
Hospitalization	10%
Emergency services	10%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 10%
Laboratory and radiology services	10%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	10%
Ambulatory outpatient services	10%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY** PCY = Per calendar year

This plan is only available to American Indians and Alaska natives who qualify. For more information, including premium rates, **visit wahealthplanfinder.org.**

PRIMARY CARE

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE

These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

*Nutrition counseling may be covered as preventive when certain requirements are met.

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Plan offered and underwritten by Kaiser Foundation Health Plan of Washington

KAISER PERMANENTE®

Individual and Family Plans

Bronze AIAN

If you are American Indian or Alaska Native (AIAN), you may be eligible for this health plan. This plan features the Core network, which offers you access to specially selected providers for the greatest value. There is no cost sharing for items and services received through Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Effective Jan. 1, 2017. Available through Washington Healthplanfinder.

CALENDAR COSTS

Annual deductible	$7,150 Indiv / $14,300 Family
Coinsurance	0%
Out-of-pocket maximum	$7,150 Indiv / $14,300 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	0%
Prescription drugs Costs per 30-day supply	Generic: 0% Brand: 0% Specialty: 0%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: 0% Brand: 0% Specialty: 0%
Urgent care	Primary: 0%
Hospitalization	0%
Emergency services	0%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 0%
Laboratory and radiology services	0%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	0%
Ambulatory outpatient services	0%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆ 1 pair frames and lenses PCY, or annual supply of contacts in lieu of eyeglasses

◆ **DEUCTIBLE DOES NOT APPLY** PCY = Per calendar year

This plan is only available to American Indians and Alaska natives who qualify. For more information, including premium rates, **visit wahealthplanfinder.org.**

PRIMARY CARE

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE

These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

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Plan offered and underwritten by Kaiser Foundation Health Plan of Washington

KAISER PERMANENTE®

Individual and Family Plans

Flex Bronze AIAN

If you are American Indian or Alaska Native (AIAN), you may be eligible for this health plan. This plan features the Core network, which offers you access to specially selected providers for the greatest value. There is no cost sharing for items and services received through Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Effective Jan. 1, 2017. Available through Washington Healthplanfinder.

CALENDAR COSTS

Annual deductible	$7,000 Indiv / $14,000 Family
Coinsurance	20%
Out-of-pocket maximum	$7,150 Indiv / $14,300 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	First 3 visits = ◆, then 20% Primary: $40 Specialty: 20%
Prescription drugs Costs per 30-day supply	Generic: $25 ◆ Brand: 40% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: $20 ◆ Brand: 35% Specialty: 50%
Urgent care	Primary: $40 or 20%
Hospitalization	20%
Emergency services	20%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	 Covered in full ◆ 20%
Laboratory and radiology services	20%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	 20% 20% 20%
Ambulatory outpatient services	20%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY** PCY = Per calendar year

This plan is only available to American Indians and Alaska natives who qualify. For more information, including premium rates, **visit wahealthplanfinder.org.**

PRIMARY CARE (LOWER COPAY)

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE (HIGHER COPAY)

These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

*Nutrition counseling may be covered as preventive when certain requirements are met.

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Plan offered and underwritten by Kaiser Foundation Health Plan of Washington

KAISER PERMANENTE®

Individual and Family Plans

VisitsPlus Silver AIAN HD

If you are American Indian or Alaska Native (AIAN), you may be eligible for this health plan. This plan features the Core network, which offers you access to specially selected providers for the greatest value. There is no cost sharing for items and services received through Indian Health Services (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Effective Jan. 1, 2017. Available through Washington Healthplanfinder.

CALENDAR COSTS

Annual deductible	$7,150 Indiv / $14,300 Family
Coinsurance	0%
Out-of-pocket maximum	$7,150 Indiv / $14,300 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	Unlimited office visits prior to deductible = ◆ Primary: $30 ◆ Specialty: $55 ◆
Prescription drugs Costs per 30-day supply	Generic: $12 ◆ Brand: $55 ◆ Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: $7 ◆ Brand: $50 ◆ Specialty: 50%
Urgent care	Primary: $30
Hospitalization	0%
Emergency services	0%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	 Covered in full ◆ 0%
Laboratory and radiology services	0%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	 0% Specialty: $55 ◆ 0%
Ambulatory outpatient services	0%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆ 1 pair frames and lenses PCY, or annual supply of contacts in lieu of eyeglasses

◆ **DEDUCTIBLE DOES NOT APPLY** PCY = Per calendar year

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PRIMARY CARE (LOWER COPAY)
These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE (HIGHER COPAY)
These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

*Nutrition counseling may be covered as preventive when certain requirements are met.

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KAISER PERMANENTE®

Individual and Family Plans

Flex Silver AIAN

If you are American Indian or Alaska Native (AIAN), you may be eligible for this health plan. This plan features the Core network, which offers you access to specially selected providers for the greatest value. There is no cost sharing for items and services received through Indian Health Services (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Effective Jan. 1, 2017. Available through Washington Healthplanfinder.

CALENDAR COSTS

Annual deductible	$1,750 Indiv / $3,500 Family
Coinsurance	30%
Out-of-pocket maximum	$6,850 Indiv / $13,700 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	First 4 primary or specialty visits = ◆ Primary: $20 Specialty: $45
Prescription drugs Costs per 30-day supply	Generic: $10 ◆ Brand: 40% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: $5 ◆ Brand: 35% Specialty: 50%
Urgent care	Primary: $20
Hospitalization	30%
Emergency services	$200 + 30%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 30%
Laboratory and radiology services	30%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	30% Specialty: $45 30%
Ambulatory outpatient services	30%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY** PCY = Per calendar year

This plan is only available to American Indians and Alaska natives who qualify. For more information, including premium rates, **visit wahealthplanfinder.org.**

PRIMARY CARE (LOWER COPAY)

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE (HIGHER COPAY)

These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

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KAISER PERMANENTE®

Individual and Family Plans

Flex Gold AIAN

If you are American Indian or Alaska Native (AIAN), you may be eligible for this health plan. This plan features the Core network, which offers you access to specially selected providers for the greatest value. There is no cost sharing for items and services received through Indian Health Services (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Effective Jan. 1, 2017. Available through Washington Healthplanfinder.

CALENDAR COSTS

Annual deductible	$850 Indiv / $1,700 Family
Coinsurance	20%
Out-of-pocket maximum	$5,000 Indiv / $10,000 Family

COMMONLY USED BENEFITS

	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	First 5 primary or specialty visits = ◆ Primary: $10 Specialty: $30
Prescription drugs Costs per 30-day supply	Generic: $10 ◆ Brand: $35 ◆ Specialty: 40%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: $5 ◆ Brand: $30 ◆ Specialty: 40%
Urgent care	Primary: $10
Hospitalization	20%
Emergency services	$200 + 20%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 20%
Laboratory and radiology services	20%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	20% Specialty: $30 20%
Ambulatory outpatient services	20%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY** PCY = Per calendar year

This plan is only available to American Indians and Alaska natives who qualify. For more information, including premium rates, **visit wahealthplanfinder.org.**

PRIMARY CARE (LOWER COPAY)

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE (HIGHER COPAY)

These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

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Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kaiser Permanente:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Kaiser Permanente Civil Rights Coordinator.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Kaiser Permanente Civil Rights Coordinator, Kaiser Foundation Health Plan of Washington Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@kp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Kaiser Permanente Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711）.

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

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Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ បេយ័តន៖** បើសិនអ្កនិយាខែរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំអេអក។ ចូរទូ រស័ព1-888-901-4636 (TTY: 1-800-833-6388 / 711។

日本語(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.