

# KAISER PERMANENTE CHOICE SOLUTION

A *CHOICE* Administrators® Program

## ENROLLMENT GUIDE FOR EMPLOYEES



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\*HSA-Qualified High Deductible Health Plan

If you have questions regarding enrollment in Kaiser Permanente Choice Solution, please call our Customer Service Center at (800) 580-9626, Monday – Friday 8:00 a.m to 5:00 p.m.

# Your Benefit Choices

## HMO Copay Plans

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in-network through your Primary Care Physician (PCP).

- You first select a PCP (your doctor)
- Referrals to hospitals and specialists are managed by your PCP
- There are no deductibles to pay
- You pay a low copay for each office visit
- Dependents are eligible up to age 26
- You can also refer yourself to certain specialists

## POS Insurance Plan

The Kaiser Permanente POS plan (POS 20/\$1,000) enables members to obtain services from HMO providers, which provides the most attractive copays and benefits. Members are also free to obtain services from participating network providers and non-participating providers—by accepting slightly higher copays in some cases and a more limited range of covered benefits.

## PPO Insurance Plan

A PPO provides benefits with a participating network of doctors with the option of going “out-of-network” for slightly higher costs.

- PPOs do not require you to select a PCP

## High Deductible Health Plans (HDHP)

The Kaiser Permanente HDHP 1900 & HDHP 2700 are HSA-qualified High Deductible Health Plans that offer members lower monthly premiums and the ability to open a tax-favored Health Savings Account (HSA) to save and pay for out-of-pocket expenses - all while getting care from Kaiser Permanente’s top-notch physicians.

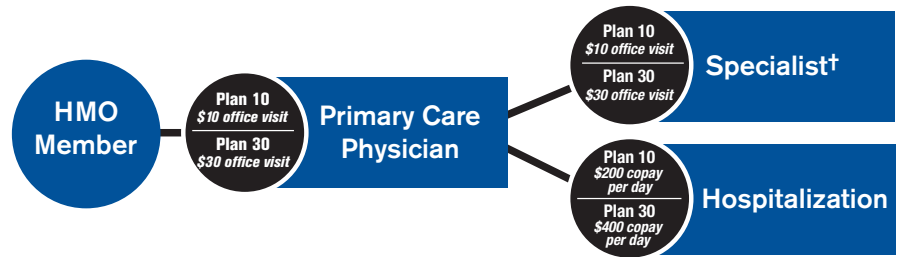
Both plans are affordable alternatives that give members the power to control their healthcare costs through lower premiums, higher plan deductibles and the ability to open a tax-favored HSA to set aside tax-free\* money to pay for qualified medical expenses like copays, deductibles, prescriptions and even eyeglasses. And, like an IRA, their funds grow tax-deferred and roll over year-after-year-which can potentially translate to substantial long-term retirement savings.

\* Tax references relate to federal income tax only. The tax treatment varies state by state. Consult with your financial, investment, or tax advisor for more information.

## Comparison of HMO, POS, PPO & HDHP Plans

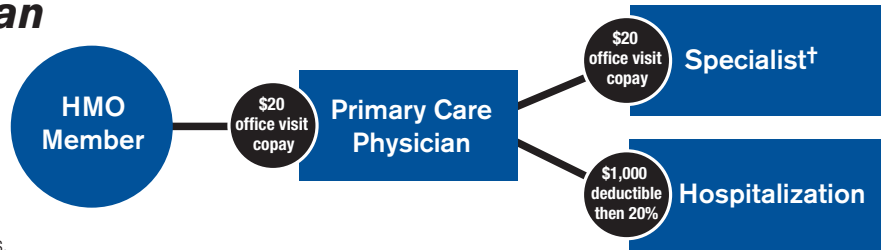
### HMO Copay Plan

Under a Kaiser Permanente Traditional HMO plan (Plan 10 and Plan 30), access to specialists and hospitalization is coordinated through the member's Primary Care Physician (PCP). These plans feature flat copays, no annual individual/family deductible and an out-of-pocket maximum.



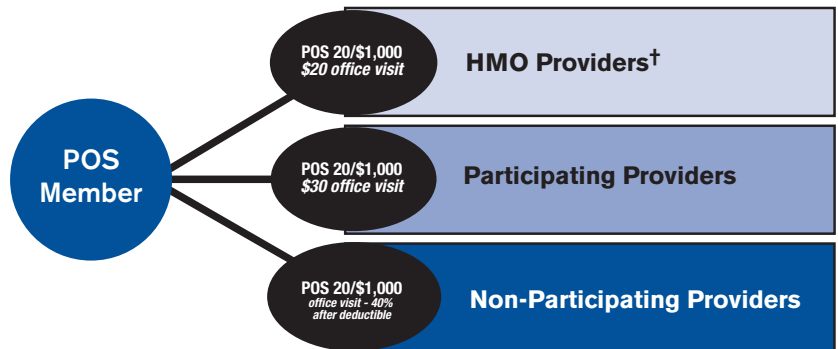
### HMO Deductible Plan

Kaiser Permanente also offers a lower premium HMO deductible plan (Plan 20/\$1,000) with an annual deductible of \$1,000/\$2,000 (individual/family) and coinsurance on some provider services. However, many preventive services (doctor office visits, lab and generic drugs) are accessed with a flat copay (without the need to satisfy deductible) and you still enjoy the financial protection offered by annual out-of-pocket limits.



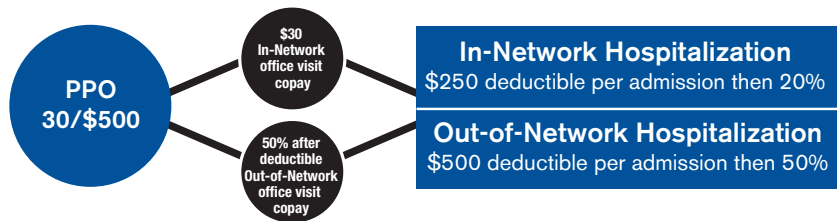
### POS Plan

Kaiser Permanente's POS plan (POS 20/\$1,000) enables members to obtain services from HMO providers, which provide the most attractive copays and benefits. Members are also free to obtain services from participating providers and non-participating providers--by accepting slightly higher copays in some cases and a more limited range of covered benefits.



### PPO Plan

Under a PPO plan, members do not choose a Primary Care Physician (PCP). PPO members may self-refer to specialists. Members can receive two levels of care, from either in-network or out-of-network physicians.



### High Deductible Health Plan

Members receive medical services from a Kaiser Permanente Primary Care Physician and may also open and contribute funds to an optional Health Savings Account (HSA) that allows them to save and pay for qualified medical expenses on a federally tax-free\*\* basis.



\* HSA-Qualified High Deductible Health Plan

\*\* Tax references relate to federal income tax only. The tax treatment varies state by state. Consult with your financial, investment, or tax advisor for more information.

† There is no prior authorization or referral for OB/GYN (can be primary provider). Self-referral is available for certain specialties and varies by geographical region.

## HMO Summary of Benefits

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE CERTAIN COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

MEDICAL BENEFITS	HMO 10	HMO 30	HMO 20/\$1,000
	Member pays	Member pays	Member pays
Calendar Year Deductible: Individual / Family	No deductible	No deductible	\$1,000 / \$2,000 (applies to out of pocket max.) <sup>(1)</sup>
Annual Out-of-Pocket Maximum: Individual / Family <sup>(1)</sup>	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,500 / \$7,000
<b>OFFICE VISITS</b>	\$10 copay	\$30 copay	\$20 copay <sup>(3)</sup>
<b>LAB AND X-RAY</b>	\$10 copay per encounter <sup>(4)</sup>	\$10 copay per encounter <sup>(4)</sup>	\$10 copay after deductible <sup>(3)</sup>
<b>HOSPITAL CARE</b>	\$200 copay per day	\$400 copay per day	20% after deductible
Emergency Room	\$50 copay per visit (waived if admitted to hospital)	\$100 copay per visit (waived if admitted to hospital)	20% after deductible
<b>RX BENEFITS</b> (Pharmacy and Mail Order) <sup>(2)</sup>			
Prescription – Generic	\$10 copay	\$10 copay	\$10 copay
Prescription – Brand Name	\$20 copay	\$30 copay after \$100 brand prescription deductible	\$30 copay
<b>ADDITIONAL BENEFITS</b>			
Maternity (Prenatal Care)	No Charge	No Charge	No Charge
Outpatient Surgery	\$100 copay per procedure	\$250 copay per procedure	20% after deductible
Home Health Care (max. 100 two-hour visits per calendar year)	No Charge (max. 3 visits in one day)	No Charge (max. 3 visits in one day)	No Charge <sup>(5)</sup> (max. 3 visits in one day)
Skilled Nursing Facility (up to 100 days per benefit period)	\$200 copay per admission	\$400 copay per admission	20% after deductible
Ambulance Services	\$50 copay per trip	\$100 copay per trip	\$150 copay per trip after deductible
Physical, Occupational, Speech Therapy	\$10 copay	\$30 copay	\$20 copay after deductible
Mental Health Services			
In the Medical Office	\$10 copay (individual visit) \$5 copay (group visit)	\$30 copay (individual visit) \$15 copay (group visit)	\$20 copay (individual visit) <sup>(5)</sup> \$10 copay (group visit) <sup>(5)</sup>
In the Hospital	\$200 copay per day	\$400 copay per day	20% after deductible
Chemical Dependency Services:			
In the Medical Office	\$10 copay (individual visit) \$5 copay (group visit)	\$30 copay (individual visit) \$5 copay (group visit)	\$20 copay (individual visit) <sup>(5)</sup> \$5 copay (group visit) <sup>(5)</sup>
In the Hospital (detoxification only)	\$200 copay per day	\$400 copay per day	20% after deductible

<sup>1</sup> The Annual Out-of-Pocket Maximum is the limit to the total amount that an individual or family must pay for certain Services in a Calendar Year (as discussed in the Evidence of Coverage). There are some benefits that do not apply toward the deductible. Amounts you pay for covered services subject to the deductible, and some other services as described under "Deductibles" in the Evidence of Coverage, apply toward the annual Out-Of-Pocket maximum.

<sup>2</sup> Prescription drugs covered in accord with the Kaiser Permanente formulary when prescribed by a Plan Physician and obtained at Plan Pharmacies. A few drugs have different copay; please refer to the Evidence of Coverage for detailed information about prescription drug copay.

<sup>3</sup> \$10 copay per encounter (except that MRI, CT, and PET are \$50 copay per procedure) after Deductible.

<sup>4</sup> \$10 copay per encounter (except that MRI, CT, and PET are \$50 per procedure).

<sup>5</sup> The deductible does not apply to the following plan provider office visits: Physician office visits, Adult preventive screening, Well-Child preventive care visits, Family planning visits, Scheduled prenatal care and first postpartum visit, Eye exams, Hearing tests, Allergy testing, Health education, Home Health Care, Mental Health.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

## POS Summary of Benefits

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE CERTAIN COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CERTIFICATE OF INSURANCE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

POS 20 / \$1,000			
MEDICAL BENEFITS	HMO	PHCS Providers (PPO)	Non-Participating Providers (out-of-network)
	Member pays	Member pays	Member pays
Calendar Year Deductible: Individual / Family	No deductible	\$1,000 / \$3,000 <sup>(1)</sup>	\$1,000 / \$3,000 <sup>(1)</sup>
<b>OFFICE VISITS</b>	\$20 copay	\$30 copay	40% <sup>(10)</sup> after deductible
<b>LAB AND X-RAY</b>	No Charge	20% after deductible	40% <sup>(10)</sup> after deductible
<b>HOSPITAL CARE</b>	\$250 copay per admission	20% after \$250 deductible per admission <sup>(4)</sup>	40% (Max per day \$1,000)
Emergency Room	\$100 copay <sup>(6)</sup> per visit (waived if admitted to hospital)	\$100 copay <sup>(11)</sup> per visit, regardless of facility / hospital accessed	\$100 copay <sup>(11)</sup> per visit, regardless of facility / hospital accessed
<b>RX BENEFIT<sup>(8) (9)</sup></b>			
Prescription – Generic	\$10 copay	\$20 copay (if obtained at participating pharmacies) <sup>(6)(7)</sup>	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$30 copay	\$40 copay after \$250 Brand deductible (if obtained at participating pharmacies) <sup>(6)(7)</sup>	Not covered (if obtained at non-participating pharmacies)
Prescription – Most Non-Formulary	\$40 copay	\$50 copay after \$250 deductible (if obtained at participating pharmacies) <sup>(6)(7)</sup>	Not covered (if obtained at non-participating pharmacies)
Prescription – Mail Order	Generic - \$10 copay (1-30 days) \$20 copay (31-100 days)  Brand - \$30 copay (1-30 days) \$60 copay (31-100 days)	Not Covered	Not covered (if obtained at non-participating pharmacies)
<b>ADDITIONAL BENEFITS</b>			
Maternity (Prenatal Care)	No Charge	20% after deductible	40% <sup>(10)</sup> after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$1,500 / \$3,000	\$3,000 / \$9,000 <sup>(2)</sup>	\$4,500 / \$13,500 <sup>(2)</sup>
Maximum Benefit while insured	Unlimited	\$2,000,000 <sup>(3)</sup>	\$2,000,000 <sup>(3)</sup>
Outpatient Surgery	\$100 copay per procedure	20% after deductible	40% <sup>(10)</sup> after deductible
Home Health Care (up to 100 2-hour visits per calendar year)	No charge	20% after deductible (Combined maximum deductible of \$50 per calendar year)	20% after deductible (Combined maximum deductible of \$50 per calendar year)
Skilled Nursing Facility Care (up to 100 days per benefit period)	\$250 copay per admission	20% after \$250 deductible per admission (Combined maximum 60 visits per calendar year)	40% after \$500 deductible per admission (Combined maximum 60 visits per calendar year)
Ambulance Services	\$50 copay per trip	\$50 copay <sup>(11)</sup> per trip	\$50 copay <sup>(11)</sup> per trip
Physical, Occupational, Speech Therapy	\$20 copay	\$30 copay 60 combined max visits per calendar year	40% 60 combined max visits per calendar year
<b>Mental Health Services</b>			
In the Medical Office	\$20 copay (individual visit) \$10 copay (group visit)	\$30 copay	40% after deductible
In the Hospital	\$250 copay per admission	20% after \$250 deductible per admission	40% (max. per day \$1,000)
<b>Chemical Dependency Services</b>			
In the Medical Office	\$20 copay (individual visit) \$5 copay (group visit)	\$30 copay	40% after deductible
In the Hospital	\$250 copay per admission (detoxification only)	20% after \$250 deductible per admission (detoxification only)	40% (max. per day \$1,000) (detoxification only)

This chart only describes a summary of benefits. For a complete understanding of benefits, please read this summary in conjunction with the Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this Benefit Summary is not intended for use as a Summary Plan Description, nor is it designed to serve as the Certificate of Insurance.

The POS Insurance Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, Inc. KFHP underwrites the HMO Providers tier, and KPIC underwrites the Participating and Non-Participating Providers tiers.

### Footnotes

- <sup>(1)</sup> Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- <sup>(2)</sup> Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier will accumulate toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier. Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier will not accumulate toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier.
- <sup>(3)</sup> Maximum benefit amount while insured is combined for services provided by Participating Providers and Non-Participating Providers.
- <sup>(4)</sup> Per admission deductibles do not contribute to the Calendar Year Deductible or the Out-of-Pocket Maximum.
- <sup>(5)</sup> Emergency medical services are covered by Kaiser Foundation Health Plan, Inc. Non-emergency medical services received in an emergency care setting that are not covered as a Health Plan benefit may be eligible for coverage by KPIC. Emergency Department surcharge fees are not covered by KPIC.
- <sup>(6)</sup> Participating Pharmacies are Albertsons, Kmart, Longs, Raley's, Rite Aid, Safeway, Sav-on, Vons, and Walgreens.
- <sup>(7)</sup> Pharmacy copays and deductibles are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription medications are excluded from coverage.
- <sup>(8)</sup> Non-formulary prescriptions are underwritten by Kaiser Permanente Insurance Company.
- <sup>(9)</sup> Prescription drugs covered in accord with the Kaiser Permanente formulary when prescribed by a Plan Physician and obtained at Plan Pharmacies. A few drugs have different copays; please refer to the Evidence of Coverage for detailed information about prescription drug copays.
- <sup>(10)</sup> Payments are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service. Maximum Allowable Charge is the lesser of: the Usual, Customary, and Reasonable Charges; the Negotiated Rate; and the Actual Billed Charges for Covered Services.
- <sup>(11)</sup> Emergency visits and ambulance for emergency medical conditions are covered as an HMO benefit for services received at any provider. Copayments paid for Emergency visits and ambulance for emergency medical conditions are not subject to, nor do they contribute towards, satisfaction of either the Calendar Year Deductible or the Out-of-Pocket Maximum.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

Pending Regulatory Approval

### Participating Providers and Non-Participating Providers exclusions and limitations

Unless specifically covered under the Group Policy, expenses incurred in connection with the following services are excluded: Charges, services, or care that are provided or reimbursed by Kaiser Foundation Health Plan, Inc. (KFHP); not medically necessary; in excess of the Maximum Allowable Charge; not available in the United States; for personal comfort; not completed in accordance with the Physician's orders. Emergency Department facility fees or charges for nonemergency weekend (Friday through Sunday) hospital admissions. Charges arising from work or that can be covered under workers' compensation or any similar law, or for which the Group Policyholder or Member is required by law to maintain alternative insurance or coverage. Charges for military service related conditions or where care is provided at government expense. Services or care provided in a Member's home, by a family member, or by a resident of the household. Dental care and dental X-rays, appliances, or orthodontia, including surgery on the jawbone, unless due to injury to natural teeth. Cosmetic services; plastic surgery; sex transformation; sexual dysfunction; surrogacy arrangements; biotechnology drugs or diagnostics; nonprescription drugs or medicines; treatment, procedures, or drugs Kaiser Permanente Insurance Company (KPIC) determines to be experimental or investigational. Education, counseling, therapy, or care for learning deficiencies or behavioral problems. Services, care, or treatment of or in connection with obesity or weight management. Services, care, or treatment of or in connection with craniomandibular or temporomandibular joint disorders, unless for medically necessary surgical treatment of the disorder. Services, care, or treatment of or in connection with musculoskeletal therapy; health education; biofeedback; hypnotherapy; routine adult physical exams; immunizations; medical social services; hearing exams, aids, or therapy; radial keratotomy or similar procedures; reversal of sterilization; or routine foot care. Services or care required by a court of law or for insurance, travel, employment, school, camp, government licensing, or similar purposes. Transplants, including donor costs. Custodial care; care in an intermediate care facility; maintenance therapy for rehabilitation; or living or transportation expenses. Treatment of mental illness; substance abuse. Services or supplies necessary to treat an injury to which a contributing cause was a Member's: commission of or attempt to commit a felony; engagement in an illegal occupation; intoxication or being under the influence of a narcotic, unless administered by a Physician. Services of a private-duty nurse. Vision care, including routine exams, eye refractions, orthoptics, glasses, contact lenses, or fittings. Drugs and medicines for the purpose of smoking cessation. Extended well-child care for children ages 17–18. Services for which no charge is normally made in the absence of insurance.

## PPO Summary of Benefits

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PPO 30 / \$500		
MEDICAL BENEFITS	Participating Network Providers Member pays	Non-Participating Network Providers Member pays
Calendar Year Deductible: Individual / Family	\$500/\$1,500 <sup>(1)</sup>	\$750/\$2,250 <sup>(1)</sup>
<b>OFFICE VISITS</b>	\$30 copay <sup>(5)(9)</sup>	50% after deductible
<b>LAB AND X-RAY</b>	20% after deductible <sup>(5)(9)</sup>	50% after deductible
<b>HOSPITAL CARE</b>	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>
Emergency Room	20% after deductible	20% after deductible
<b>RX BENEFITS</b>		
Prescription – Generic	\$15 copay <sup>(5)(7)</sup> (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$40 copay <sup>(5)(7)</sup> after \$250 deductible (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Most Non-Formulary	\$60 copay <sup>(5)(7)</sup> after \$250 deductible (if obtained at participating pharmacies)	Not covered
Prescription – Mail Order	2x the corresponding single copay per prescription, up to 100 day supply	Not covered (if obtained at non-participating pharmacies)
<b>ADDITIONAL BENEFITS</b>		
Maternity (Prenatal Care)	20% after deductible	50% after deductible
Chiropractic	\$15 copay 20 combined visits \$50 allowance for Chiro appliance annually	N/A
Annual Out-of-Pocket Maximum: Individual / Family	\$2,000 / \$6,000 <sup>(2)</sup>	\$6,000 / \$18,000 <sup>(2)</sup>
Maximum Benefit while insured	Unlimited	\$5,000,000 <sup>(3)</sup>
Outpatient Surgery	20% after deductible	50% after deductible
Home Health Care (up to 100 combined 2-hour visits per calendar year)	20% <sup>(10)</sup> after deductible	20% <sup>(10)</sup> after deductible
Skilled Nursing Facility Care	20% after \$250 deductible per admission <sup>(4)</sup> (Combined maximum 60 visits per calendar year)	50% after \$500 deductible per admission <sup>(4)</sup> (Combined maximum 60 visits per calendar year)
Ambulance Services	40% <sup>(6)</sup> after deductible	40% <sup>(6)</sup> after deductible
Physical, Occupational, Speech Therapy	20% 60 combined max visits per calendar year	50% 60 combined max visits per calendar year
Mental Health Services		
In the Medical Office – Severe mental illness <sup>(8)</sup>	\$30 copay <sup>(5)(9)</sup>	50% after deductible
In the Hospital – Severe mental illness <sup>(8)</sup>	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>
In the Medical Office – All other covered mental illness	\$30 copay <sup>(5)(9)</sup>	50% after deductible
In the Hospital – All other covered mental illness	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>
Chemical Dependency Services		
In the Medical Office	\$30 copay <sup>(5)(9)</sup>	50% after deductible
In the Hospital (detoxification only)	20% after \$250 deductible per admission <sup>(4)</sup>	50% after \$500 deductible per admission <sup>(4)</sup>

This chart only describes a summary of benefits. For a complete understanding of benefits, please read this summary in conjunction with the Kaiser Permanente Insurance Company Certificate of Insurance, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this chart is not intended for use as a Summary Plan Description, nor is it designed to serve as the Certificate of Insurance.

The PPO Insurance Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, Inc.

### Footnotes

- <sup>(1)</sup> Covered Charges applied to satisfy Deductibles at the Participating Provider level will not be applied towards satisfaction of Deductibles at the Non-Participating Provider level. Likewise, Covered Charges applied to satisfy Deductibles at the Non-Participating Provider level will not be applied towards satisfaction of the Deductibles at the Participating Provider Level.
- <sup>(2)</sup> Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier will accumulate toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier. Covered Charges incurred toward satisfaction of the Out-of-Pocket Maximum at the Participating Providers tier will not accumulate toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers tier.
- <sup>(3)</sup> Maximum benefit while insured for services provided by Non-Participating Providers.
- <sup>(4)</sup> Per admission inpatient deductibles do not contribute toward the Calendar Year Deductible or the Out-of-Pocket Maximum.
- <sup>(5)</sup> Exempt from deductibles.
- <sup>(6)</sup> The Participating Provider Network does not contract for ambulance coverage. Therefore, medically necessary non-emergency ambulance service is payable at the Non-Participating Providers level. Non-emergency ambulance coverage is limited to a maximum of \$2,000 per calendar year for all KPIC-covered services.
- <sup>(7)</sup> MedCare Pharmacy copays are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from this coverage.
- <sup>(8)</sup> Severe Mental Illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- <sup>(9)</sup> Deductibles, including the Calendar Year Deductible, Coinsurance and Copayments do not apply to Preventive Benefits required under the Patient Protection Affordable Care Act (PPACA) provided by PHCS Providers.
- <sup>(10)</sup> Combined maximum deductibles of \$50 per calendar year.

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### Participating Providers and Non-Participating Providers exclusions and limitations

Unless specifically covered under the Group Policy, expenses incurred in connection with the following services are excluded: Charges, services, or care that are provided or reimbursed by Kaiser Foundation Health Plan, Inc. (KFHP); not medically necessary; in excess of the Maximum Allowable Charge; not available in the United States; for personal comfort; not completed in accordance with the Physician's orders. Emergency Department facility fees or charges for nonemergency weekend (Friday through Sunday) hospital admissions. Charges arising from work or that can be covered under workers' compensation or any similar law, or for which the Group Policyholder or Member is required by law to maintain alternative insurance or coverage. Charges for military service related conditions or where care is provided at government expense. Services or care provided in a Member's home, by a family member, or by a resident of the household. Dental care and dental X-rays, appliances, or orthodontia, including surgery on the jawbone, unless due to injury to natural teeth. Cosmetic services; plastic surgery; sex transformation; sexual dysfunction; surrogacy arrangements; biotechnology drugs or diagnostics; nonprescription drugs or medicines; treatment, procedures, or drugs Kaiser Permanente Insurance Company (KPIC) determines to be experimental or investigational. Education, counseling, therapy, or care for learning deficiencies or behavioral problems. Services, care, or treatment of or in connection with obesity or weight management. Services, care, or treatment of or in connection with craniomandibular or temporomandibular joint disorders, unless for medically necessary surgical treatment of the disorder. Services, care, or treatment of or in connection with musculoskeletal therapy; health education; biofeedback; hypnotherapy; immunizations; medical social services; hearing exams, aids, or therapy; radial keratotomy or similar procedures; reversal of sterilization; or routine foot care. Services or care required by a court of law or for insurance, travel, employment, school, camp, government licensing, or similar purposes. Transplants, including donor costs. Custodial care; care in an intermediate care facility; maintenance therapy for rehabilitation; or living or transportation expenses. Services or supplies necessary to treat an injury to which a contributing cause was a Member's: commission of or attempt to commit a felony; engagement in an illegal occupation; intoxication or being under the influence of a narcotic, unless administered by a Physician. Services of a private-duty nurse. Vision care, including routine exams, eye refractions, orthoptics, glasses, contact lenses, or fittings. Drugs and medicines for the purpose of smoking cessation. Services for which no charge is normally made in the absence of insurance.

## HDHP Summary of Benefits

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MEDICAL BENEFITS	HDHP 1900*	HDHP 2700*
	Member Pays	Member Pays
Calendar Year Deductible: Individual / Family <sup>(1)</sup>	\$1,900 / \$3,800	\$2,700 / \$5,400
Annual Out-of-Pocket Maximum: Individual / Family <sup>(2)</sup>	\$3,400 / \$6,800	\$5,000 / \$10,000
<b>PREVENTIVE CARE<sup>(4)</sup></b>		
Routine Physical	\$0 no deductible	\$30 per visit no deductible
<b>OFFICE VISITS</b>	\$0 per visit after deductible	\$30 copay after deductible
<b>LAB AND X-RAY-OUTPATIENT</b>	\$0 after deductible	\$10 per encounter after deductible
<b>LAB AND X-RAY-MRI/CT/PET</b>	\$50 per procedure after deductible	\$50 per procedure after deductible
<b>HOSPITAL CARE</b>	\$300 per day after deductible	20% per admission after deductible
Emergency Room	\$100 per visit after deductible	20% per visit after deductible
<b>RX BENEFITS<sup>(3)</sup></b>		
Prescription – Generic	\$10 copay after deductible	\$10 copay after deductible
Prescription – Brand	\$30 copay after deductible	\$30 copay after deductible
Prescription – Mail Order - Generic	\$10 copay after deductible (1-30 days) \$20 copay after deductible (31-100 days)	\$10 copay after deductible (1-30 days) \$20 copay after deductible (31-100 days)
Prescription – Mail Order - Brand	\$30 copay after deductible (1-30 days) \$60 copay after deductible (31-100 days)	\$30 copay after deductible (1-30 days) \$60 copay after deductible (31-100 days)
<b>ADDITIONAL BENEFITS</b>		
Maternity (Prenatal Care)	\$0 no deductible	\$0 no deductible
2nd Surgical Opinion	\$0 per visit after deductible	\$30 copay after deductible
Outpatient Surgery	\$150 per procedure after deductible	20% after deductible
Home Health Care (Max. 100 two-hour visits per year)	\$0 per visit after deductible	\$0 per visit after deductible
Skilled Nursing Facility Care (100-day limit per benefit period)	Extended Care-\$0 per admission after deductible	Extended Care-20% per admission after deductible
Ambulance Services	\$100 per trip after deductible	20% per trip after deductible
Physical, Occupational, Speech Therapy	\$0 after deductible	\$30 copay after deductible
Mental Health Services		
Doctor Fees	\$0 per visit after deductible	\$30 copay per visit after deductible
Hospital Care	\$300 per day after deductible	20% per admission after deductible
Chemical Dependency Services		
In the Medical Office	\$0 per visit after deductible	\$30 per visit after deductible
In the Hospital	\$300 per day after deductible	20% per admission after deductible

\*HSA - Qualified High Deductible Health Plan

The High Deductible Health Plans are underwritten by Kaiser Permanente Health Plan (KFHP).

### Footnotes

- <sup>(1)</sup> For Self enrollment coverage, the entire Individual Annual Deductible must be met before copay or coinsurance is applied for the individual member. For Family coverage, the entire Family Annual Deductible must be met before copay or coinsurance is applied for any individual family member. For Plan 2700, the family deductible contains an embedded individual deductible, meaning any member of the family never satisfies more than the individual deductible.
- <sup>(2)</sup> The Annual Out-of-Pocket Maximum is the limit to the total amount that an individual or family must pay for certain Services in a Calendar Year (as discussed in the *Evidence of Coverage*). For Self enrollment coverage, the entire Individual Annual Out-of-Pocket Maximum must be met before the limit is applied for the individual member. For Family coverage, the entire Family Annual Out-of-Pocket Maximum must be met before the limit is applied for any individual family member.
- <sup>(3)</sup> Prescription drugs covered in accord with the Kaiser Permanente formulary when prescribed by a Plan Physician and obtained at Plan Pharmacies. A few drugs have different copay; please refer to the *Evidence of Coverage* for detailed information about prescription drug copay.
- <sup>(4)</sup> Pursuant to recent federal law changes, certain preventive services are not subject to these or any copayments. Please see your *Evidence of Coverage*.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

\*HSA-Qualified High Deductible Health Plan

# Tools to Enroll

These are the tools available to help you enroll.

You will need to decide:

- If you want HMO, POS, PPO or HDHP\* benefits
- What you're willing to pay for your coverage
- The benefit level you want
- The doctor you want

Search for doctors online at:  
[www.kpchoicesolution.com](http://www.kpchoicesolution.com)

## Enrollment Application

Must be filled out completely and signed on page 3

## Personalized Worksheet

Shows your employer's contribution and your additional costs for every coverage option

## Kaiser Permanente Choice Solution Online Doctor Search

Find your doctor at  
[www.kpchoicesolution.com](http://www.kpchoicesolution.com)

\*HSA-Qualified High Deductible Health Plan

# Your Personalized Worksheet

Use your Personalized Worksheet to:

- Review the basic benefits
- Select an HMO, POS, PPO or HDHP\* Plan
- Compare and choose your benefit level

Verify your age and home Zip Code

**Kaiser Permanente Choice Solution**

**EMPLOYEE ENROLLMENT WORKSHEET**

Effective Date: 10/01/11  
Quote #: 697315  
Employer Zip Code: 92868

**SAMPLE QUOTE 10.1.11**  
Sample Employee - Age 25  
Residence Zip Code: 92868

HMO Plans	HMO 10	HMO 30	20/\$1,000 Deductible	HDHP 1900	HDHP 2700
<b>In-Network</b>	Yes	Yes	Yes	Yes	Yes
HMO Network Required	None	None	None	\$1,900/\$3,800 ①	\$2,700/\$5,400 ①
Deductible Ind/Fam	\$10 per visit	\$30 per visit	\$20 per visit	No charge ②	\$30 per visit ②
Dr. Office Visits	\$200 per day	\$400 per day	80% after deductible	\$300 per day ②	80% after deductible
Hospital Care	\$10 per presc.	\$10 per presc.	\$10 per presc.	\$10 per presc. ②	\$10 per presc. ②
Rx Benefit (Generic)	\$20 per presc.	\$100 ded. - \$30 per presc.	\$30 per presc.	\$30 per presc. ②	\$30 per presc. ②
Rx Benefit (Brand)	\$1,500/\$3,000	\$3,000/\$6,000	\$3,500/\$7,000	\$3,400/\$6,800 ③	\$5,000/\$10,000 ③
Out-Of-Pocket Max. - Ind/Fam					

All eligible HMO benefits are covered In-Network only.

POS Plan	POS 20/\$1,000 *	Participating PPO Providers
<b>In-Network</b>	Yes - HMO	Yes
Network Required	None	\$1,000/\$3,000
Deductible Ind/Fam	\$20 per visit	\$30
Dr. Office Visits	\$250 per admission	\$250 ded. per admission-80%
Hospital Care	\$10 per presc.	\$20 per presc. ④
Rx Benefit (Generic)	\$30 per presc.	\$40 per presc. ④
Rx Benefit (Brand)	\$1,500/\$3,000	\$3,000/\$9,000
Out-Of-Pocket Max. - Ind/Fam		

Out-Of-Network	POS 20/\$1,000 *
Deductible	\$1,000/\$3,000
Dr. Office Visits	60% (max per day \$1,000)
Hospital Care	Not Covered ⑤
Rx Benefit (Generic)	Not Covered ⑤
Rx Benefit (Brand)	\$4,500/\$13,500
Out-Of-Pocket Max. - Ind/Fam	

**PPO Plan**

**PPO 30/\$500 \***

Yes \$500/\$1,500  
No \$250 deduct. waived  
\$250 ded. per admission-80%  
\$15 per presc.  
\$250 ded-\$40 per presc.  
\$2,000/\$6,000

① For Self-Only employees coverage, the entire Annual Out-of-Pocket Maximum must be met before Copayments or coinsurance is applied for the individual member. For Family coverage, the entire Family Annual Deductible must be met before Copayments or coinsurance is applied for any individual family member. For Plan Copayments or coinsurance is applied for an individual family member. For Plan Deductible, the family deductible contains an embedded individual deductible, meaning any member of the family never applies more than the individual deductible.

② After Deductible.

③ The Annual Out-of-Pocket Maximum is the limit to the total amount that an individual or family must pay for certain Services in a Calendar Year (as discussed in the Evidence of Coverage). For Self-Only enrollment coverage, the entire Individual Annual Out-of-Pocket Maximum must be met before the limit is applied for the individual member. For Family coverage, the entire Family Annual Out-of-Pocket Maximum must be met before the limit is applied for any individual family member.

④ If obtained at Participating Pharmacies.

⑤ If obtained at Non-Participating Pharmacies.

The following premiums illustrate the cost to you after your employer has made their contribution. All family members must enroll with the same Participating Plan.

Have we correctly listed your Age and Residence Zip Code above?  Yes  No (If no, your quoted premium may be incorrect. Please notify your Health Plan Administrator.)

Your Employer has agreed to contribute: 80 % of the Rate for HMO Health Plan 30  
0 % of the Dependent Rate for Same Plan as Above

**THESE ARE YOUR COSTS PER MONTH.**

HMO Plans	Employee Only	Additional cost for Spouse Only	Additional cost for Child(ren) Only	Additional cost for Family
HMO 10	\$ 140.75	\$ 616.51	\$ 600.56	\$ 992.57
HMO 30	\$ 50.76	\$ 455.12	\$ 443.34	\$ 732.73
HMO 20 / \$1,000 Deductible	\$ 12.16	\$ 374.14	\$ 271.92	\$ 494.91
HDHP 1900	\$ 2.70	\$ 357.70	\$ 259.97	\$ 473.16
HDHP 2700	\$ 0.00	\$ 258.56	\$ 187.91	\$ 342.02
<b>POS Plan</b>				
POS 20 / \$1,000	\$ 286.90	\$ 897.80	\$ 773.07	\$ 1,316.36
<b>PPO Plan</b>				
PPO 30 / \$500	\$ 328.13	\$ 1,012.17	\$ 615.79	\$ 1,204.45

Rates are guaranteed for 12 months unless you have an age change during the year that moves you to a new age band (i.e. changing to age 30, 40, 50, 55, 60, or 65). We assume no liability for rate or benefit discrepancies. See Evidence of Coverage for detailed benefits.  
\* Not available in the Kaiser Permanente Choice Solution wrap program.

Quote 697315-1.00

July 12, 2011  
kpchoicesolution.com  
Page 6

Your employer's contribution appears here

Add the dependent column to the "Employee Only" column for the total premium

Having a birthday?

Rates are guaranteed for 12 months unless your birthday moves you to a new age band

Your cost for the plan of your choice appears here — Your employer's contribution has already been subtracted

\*HSA-Qualified High Deductible Health Plan

# Enrollment Application

Please be sure to complete your application thoroughly. For example, the sections noted below are frequently overlooked.

In addition to the Employee Enrollment Application, groups with 2-14 enrolling employees must also complete the Enrollment Health Statement.

## Sign Your Application

Sign here if you are accepting coverage

**KAISER PERMANENTE CHOICE SOLUTION**  
A CHOICE Administrators' Program  
www.kpchoicesolution.com

**Medical / Dental / Life / Enrollment Application**  
Application must be COMPLETED IN FULL, SIGNED AND DATED for processing.

**A. Personal Information** Please select one:  New Hire Enrollment  New Renewal Enrollment  New COBRA Enrollment

Name of Company \_\_\_\_\_ Employee Phone # \_\_\_\_\_ Employee Job Title \_\_\_\_\_ Full-time Employment Date \_\_\_\_\_

Sex  M  F Status  Married  Single (Note: If you or any of your dependents are **not** enrolling, you must also complete and sign the waiver section on back.)  
 Domestic Partner

Employee Social Security Number \_\_\_\_\_

Employee First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Year \_\_\_\_\_ Group Number \_\_\_\_\_

Residence Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Email Address \_\_\_\_\_ Mailing Address (if different from above) \_\_\_\_\_

**B. Medical Benefit (select one plan only)**

HMO  POS  PPO  HDHP 1900\*  HDHP 2700\*  
 Plan 10  Plan 30  POS 20/\$1,000  PPO 30/\$500  HDHP 1900\*  HDHP 2700\*  
\*HSA-Qualified High Deductible Health Plan

**C. Enrollment Information (Complete this section ONLY if you are electing medical and/or dental for yourself and dependents)**

Employee	Spouse/Domestic Partner	Child/Grandchild	Child/Grandchild	Child/Grandchild
Last Name	<input type="checkbox"/> Life only			
First Name				
Relationship to Employee	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
Social Security No.				
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	/ /	/ /	/ /	/ /
Disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolling For?	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

\* Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent.  
NOTE: For additional dependent enrollment, complete sections A and C on a separate application.

**D. Optional Benefits — Ask your health plan administrator if any of the optional benefits below are being offered by your employer**

Sections A, C & E must be completed for life coverage

**DENTAL COVERAGE**

DHMO 200  PPO 1000  FFS 1000  DHMO 250  PPO 1500  FFS 1500

**LIFE INSURANCE**

Full Name of Beneficiary \_\_\_\_\_ Relationship of Beneficiary \_\_\_\_\_ Date of Birth of Beneficiary \_\_\_\_\_

**PREMIUM ONLY PLAN (P.O.P.)**

I want my portion of eligible insurance premiums paid on a pre-tax basis

(1 of 4) PLEASE SIGN AND DATE APPLICABLE SECTIONS ON THE REVERSE SIDE OF FORM KP 0310 6/2011

Select Marital Status

Include date of hire

Include Social Security Numbers for dependents

Sign here if you are waiving coverage for yourself or any dependents

**E. Your LEGAL Acknowledgment (Read, Sign & Date Below)**

By submitting this signed application, I agree and understand that the health plan chosen through the Kaiser Permanente Choice Solution program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copayments, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my and my dependents' protected health information, including medical records, to the participating Kaiser Permanente Choice Solution health plans or their authorized agents for the purpose of review, investigation or evaluation of an application or claim, and for quality assurance and utilization review. I authorize the participating Kaiser Permanente Choice Solution health plans and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understood the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employee named on this application, myself and my dependents named on this application.

- I am either actively, permanently working for the employer and considered eligible by my employer, because I work, either 20+ or 30+ hours per week, or I am an eligible COBRA/COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.
- My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed ward of me or my spouse/domestic partner.

I understand that the above statements are subject to audit at any time and agree to provide CHOICE Administrators' with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers thereafter.

I understand that any person, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTOOD and ATTEST that myself and my dependents have met all of the eligibility requirements listed on the fourth page of this application.

California law prohibits an ERG test from being required or used by health care service plans as a condition of obtaining coverage.

**Kaiser Foundation Health Plan Arbitration Agreement:** I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (to claim the medical services were unnecessary or unauthorised or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage and in the Certificate of Insurance.

1) Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service Plan; 2) the PPO Plans; and 3) the KPIC Dental Plans.

Employee Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name \_\_\_\_\_

**COBRA Applicants:** Indicate Qualifying Event:  Termination of employment  Child no longer eligible  Medicare entitlement  Death of employee  
 COBRA  Cal-COBRA  Divorce/legal separation  Divorce/legal separation  Death of employee

CHOICE Administrators' Start Date  New Hire  New Hire  Open Enrollment Effective Date: \_\_\_\_\_

(2 of 4) KP 0310A 6/2011

**Medical / Dental Waiver**

**IMPORTANT!**  
Complete this page only if you DO NOT WANT MEDICAL OR DENTAL COVERAGE for yourself and/or your eligible dependents. If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.

**A. Personal Information**

Name of Company \_\_\_\_\_ Employee Phone Number \_\_\_\_\_

Employee Last Name \_\_\_\_\_ Employee Social Security Number \_\_\_\_\_

Employee First Name \_\_\_\_\_ Group Number \_\_\_\_\_

**B. Type of Waiver**

I have been offered coverage by my employer, but at this time I wish to DECLINE coverage as follows:

1) **Medical for:**  Myself and dependents  Spouse/Domestic Partner  Child(ren)

2) **Dental for:**  Myself and dependents  Spouse/Domestic Partner  Child(ren)

**C. Reason**

Required only if waiving coverage

1) Reason waiving Medical:  
 Other group coverage Carrier Name: \_\_\_\_\_ Group # \_\_\_\_\_  
 Medicare  Medical  Individual Policy  Other Reason: \_\_\_\_\_ (explanation required)

2) Reason waiving Dental:  
 Other group coverage Carrier Name: \_\_\_\_\_ Group # \_\_\_\_\_  
 Medicare  Medical  Individual Policy  Other Reason: \_\_\_\_\_ (explanation required)

I understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee SIGN HERE TO WAIVE COVERAGE: \_\_\_\_\_ Date \_\_\_\_\_

(3 of 4) KP 0310B 6/2011

# Online Provider Directory

If you have a doctor in mind, find them at [www.kpchoicesolution.com](http://www.kpchoicesolution.com) using our Doctor search tool.

The screenshot displays the website interface for Kaiser Permanente Choice Solution. At the top, it says "WELCOME TO Kaiser Permanente Choice Solution For small businesses 2 - 50". A navigation menu includes "CONTACT US", "SITE MAP", "HELP", and "HOME". On the left, a sidebar menu lists "ABOUT US", "BENEFITS", "HEALTH PLANS", "PROVIDER / RX SEARCH" (which is highlighted), and "FORMS". The main content area is titled "PROVIDER/RX SEARCH" and contains two sections: "Provider Search" described as a directory of providers, and "Drug Encyclopedia" described as a complete listing of prescription drugs with usage and side effect information. The footer contains the copyright notice: "©2006 Kaiser Permanente Choice Solution - A CHOICE Administrators Program | Terms of Use | Privacy Notice".

# Enrollment Form

## Frequently missed sections:

- Children’s SSN, disabled dependent box
- Life beneficiary (if Life Insurance offered)
- Date of hire
- Marital status

**Kaiser Permanente Choice Solution**  
 A CHOICE Administration Program  
 www.kpchoice.com

**Medical / Dental / Life / Enrollment Application**  
 Application must be COMPLETED in FULL, SIGNED and DATED for processing.

**A. Personal Information** Please select one:  New Hire Enrollment  New Renewal Enrollment  New COBRA Enrollment

**B. Medical Benefit** (select one plan only)

**C. Enrollment Information** (Complete this section ONLY if you are electing medical and/or dental for yourself and dependent(s))

**D. Optional dependent enrollment** (complete sections A and C on a separate application)

**E. Premium Only Plan (P.O.P.)**

(1 of 4) PLEASE SIGN AND DATE APPLICABLE SECTIONS ON THE REVERSE SIDE OF FORM KP 0310 6/2011

## Waiver Form (attached to enrollment form)

Employees who waive coverage for medical and/or dental are not eligible again until the next Renewal

- Waiver must be completed if **employee waives coverage**; and/or,
  - Employee waives coverage on an eligible spouse, or dependent child
  - Be sure to check off the correct reason for waiving

**Medical / Dental Waiver**

**IMPORTANT!**  
 Complete this page only if you **DO NOT WANT MEDICAL OR DENTAL COVERAGE** for yourself and/or your eligible dependents. If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.

**A. Personal Information**

**B. Type of Waiver**

**C. Reason**

**D. Signature and Date**

(3 of 4) KP 0310B 6/2011

# Summary

- Select an **HMO, POS, PPO or HDHP\*** plan on your worksheet
- Choose your **benefit level**
- Compare health plan **costs**

- Fill out the **Enrollment Form** completely

# Important Reminders

Be sure to include the following on your application:

- Date of hire
- Date of birth
- Plan benefit level (#)
- Signature

\*HSA-Qualified High Deductible Health Plan

## Coverage for Spouse and Children / Grandchildren

- If you are enrolled and have a spouse and/or children, they may also be eligible for coverage under your plan.

SPOUSE: Must be legally married to you in order to be eligible for coverage through the Kaiser Permanente Choice Solution Program. You must agree to notify CHOICE Administrators® Insurance Services, Inc. immediately upon termination of the marriage.

MEDICAL Dependent eligibility:

- Born to or grandchild of, adopted by, stepchild of or non-temporary ward of the eligible employee, employee spouse or domestic partner
- Under age 26 (unless disabled, disability diagnosed prior to age 26)

DENTAL Dependent eligibility:

- Born to or grandchild of, adopted by, stepchild of or non-temporary ward of the eligible employee, employee spouse or domestic partner
- Dependent on the employee for at least 50% of his/her economic support
- Unmarried or not involved in a domestic partnership
- Under age 26 (unless disabled, disability diagnosed prior to age 26)

Disabled Dependents: Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday.

- You are not required to extend coverage to either your spouse or your dependent children. If you do not wish to do so, you must check the appropriate boxes and sign the WAIVER Form, stating that you decline dependent coverage.
- Any family members enrolling for coverage through the Kaiser Permanente Choice Solution Program must choose the same participating health plan and benefit design, although each is free to choose a different primary care physician.
- If you are in the middle of treatment AND your current physician is not contracted with the Health Plan you wish to select, please contact our Customer Service Center at (800) 580-9626 for further information and assistance.

## Coverage for Domestic Partner

Requirements:

The employee and domestic partner must:

- Share a common residence
- Not be married under either a statutory or common law or part of another domestic partnership
- Be 18 years of age or older
- Share an intimate and committed relationship
- Both be mentally competent
- Not be related by blood to a degree of closeness that would prohibit marriage in this state
- Agree to notify *CHOICE* Administrators® Insurance Services, Inc. immediately upon termination of the domestic partnership

Members who are in a same sex partnership or over the age of 62 are required to submit a Certificate of Registration of Domestic Partnership, all others must submit a Signed Domestic Partnership Affidavit.

## AB 88 Mental Health Parity Statement

- Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions.
- These benefits will include inpatient, partial hospitalization and outpatient services and prescription drugs if the plan includes drug coverage.
- The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copay and individual and family deductibles.
- “Severe Mental Illness” includes: schizophrenic disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa and bulimia nervosa.

[www.kpchoicesolution.com](http://www.kpchoicesolution.com)

800.580.9626

A *CHOICE* Administrators® Program

