

# KAISER PERMANENTE CHOICE SOLUTION

A *CHOICE* Administrators Program

ENROLLMENT GUIDE FOR EMPLOYEES



# Contents

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- Your Benefit Choices.....3
- Comparison of HMO, POS, PPO & Indemnity Plans .....4
- HMO Copay Plans Summary of Benefits .....5
- POS 500 Insurance Plan Summary of Benefits .....6
- POS 1000 Insurance Plan Summary of Benefits .....7
- POS 500 & POS 1000 Insurance Plans Conditions of Service .....8
- PPO 500 Insurance Plan Summary of Benefits .....9
- PPO 500 Insurance Plan Conditions of Service .....10
- Indemnity Insurance Plan Summary of Benefits.....11
- Indemnity Insurance Plan Conditions of Service .....12
- The Tools You’ll Need to Enroll .....13
- Using Your Personalized Worksheet .....14
- Complete Your Enrollment Application .....15
- Find Your Doctor/Online Provider Directory .....16
- Frequently Missed Sections/Waiver .....17
- Enrollment Procedures Summary .....18
- Coverage for Spouse and Children/Grandchildren .....19
- Coverage for Domestic Partner .....20
- AB 88 Mental Health Parity Statement .....21

If you have questions regarding enrollment in Kaiser Permanente Choice Solution, please call Member Services at (800) 580-9626, Monday – Friday 8:30 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 24

You can also refer yourself to certain specialists

### POS Insurance Plans

Kaiser Permanente's POS plans (POS 500 & POS 1000) enable 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

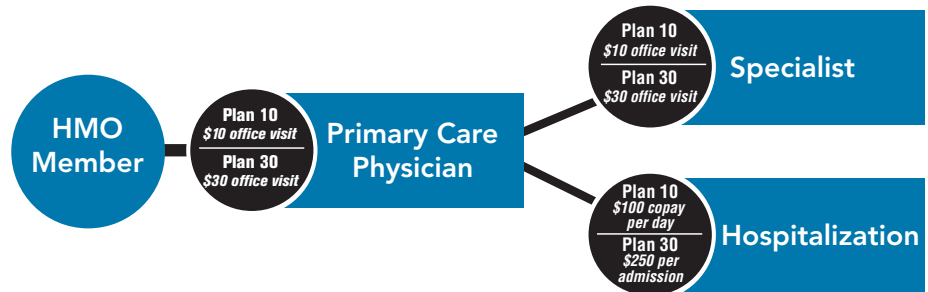
### Indemnity Insurance Plan

Indemnity plans allow a member to obtain medical services from any provider. The plan then reimburses the member a set percentage (70%, for example) of charges incurred, once the deductible is met. Kaiser Permanente Choice Solution's Indemnity plan also includes copays for doctor office visits and Generic drugs (when purchased through a MedCare Pharmacy).

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

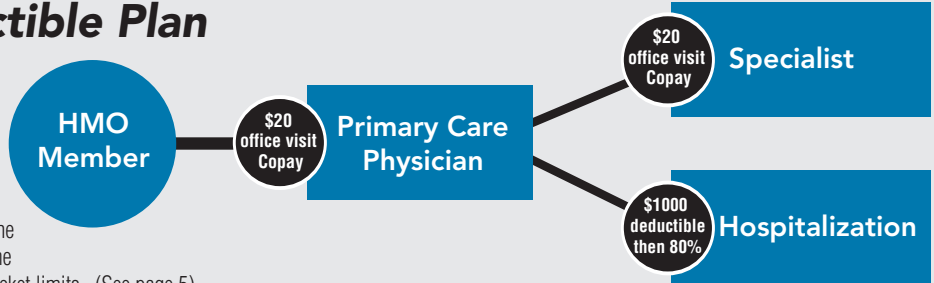
### HMO Copay Plan

Under a Kaiser Permanente Traditional HMO plan (Plan 10 and Plan 30), all 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. (See page 5)



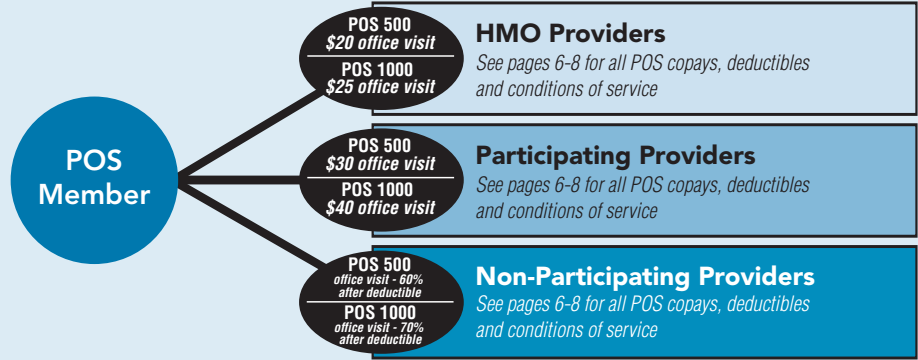
### HMO High Deductible Plan

Kaiser Permanente also offers a lower premium HMO deductible plan (Plan 20/1000) with an annual deductible of \$1000/\$2000 (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. (See page 5)



### POS Plan

Kaiser Permanente's POS plans (POS 500 and POS 1000) enable 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. (See pages 6-8)



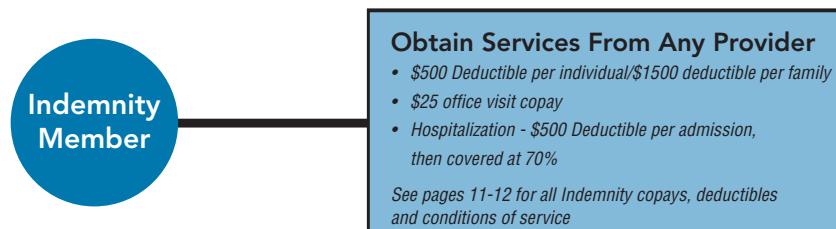
### PPO Plan

Under a PPO plan, members do not choose a Primary Care Physician (PCP). PPO members may self-referral to specialists. Members can receive two levels of care, from in-network doctors or go out-of-network for lower benefits. (See pages 9-10)



### Indemnity Plan

Indemnity plans allow a member to obtain medical services from any provider. The plan then reimburses the member a set percentage (70%, for example) of charges incurred, once the deductible is met. Kaiser Permanente Choice Solution's Indemnity plan also includes copays for doctor office visits and Generic drugs (when purchased through a MedCare Pharmacy). (See pages 11-12)



## HMO Copay Plans 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.

<b>MEDICAL BENEFITS</b>	<b>HMO 10</b>	<b>HMO 30</b>	<b>HMO 20/1000</b>
	Member pays	Member pays	Member pays
Deductible: Individual / Family	No deductible	No deductible	\$1,000 / \$2,000 (applied to OOP maximum)
<b>OFFICE VISITS</b>	<b>\$10 copay</b>	<b>\$30 copay</b>	<b>\$20 copay</b>
Lab And Imaging	\$10 copay	\$10 copay	\$10 copay
<b>HOSPITAL CARE</b>	<b>\$100 copay per day</b>	<b>\$250 copay per admission</b>	<b>20% after deductible</b>
Emergency Room	\$50 copay (waived if admitted to hospital)	\$ 100 copay (waived if admitted to hospital)	20% after deductible (waived if admitted to hospital)
<b>RX BENEFITS*</b>			
Prescription – Generic*	\$10 copay	\$10 copay	\$10 copay
Prescription – Brand Name*	\$20 copay	\$30 copay after \$100 brand prescription deductible	\$30 copay after \$100 brand prescription deductible
<b>ADDITIONAL BENEFITS</b>			
Maternity / Prenatal Care**	\$10 copay	\$15 copay	\$10 copay
Annual Out-of-Pocket Maximum: Individual / Family***	\$1,000 / \$ 2,000	\$2,000 / \$4,000	\$3,000 / \$6,000
Outpatient Surgery	\$100 copay per procedure	\$250 copay per procedure	20% after deductible
Home Health Care (up to 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 (Max. 3 visits in one day)
Skilled Nursing Facility Care: (up to 100 days per benefit period)	\$100 copay per admission	\$250 copay per admission	20% after deductible
Ambulance Services	\$50 copay	\$100 copay	\$150 copay after deductible
Mental Health Services			
In the Medical Office**** (up to 20 visits per calendar year)	\$10 copay	\$30 copay	\$20 copay
In the Hospital**** (up to 30 days per calendar year)	\$100 copay per day	\$250 copay per admission	20% after deductible
Chemical Dependency Services:			
In the Medical Office	\$10 copay	\$30 copay	20% after deductible
In the Hospital (detoxification only)	\$100 copay per admission	\$250 copay per admission	20% after deductible

\* 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 Copayments; please refer to the Evidence of Coverage for detailed information about prescription drug Copayments.

\*\* Scheduled prenatal visits and the first postpartum visit.

\*\*\* 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).

\*\*\*\* Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the Evidence of Coverage.

The HMO plans are underwritten by Kaiser Foundation Health Plan (KFHP).

## POS 500 Insurance Plan 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 500			
MEDICAL BENEFITS	HMO	Participating Network Providers	Non-Participating Network Providers
	Member pays	Member pays	Member pays
Deductible: Individual / Family	No deductible	\$500 / \$1,500 <sup>(1)</sup>	\$500 / \$1,500 <sup>(1)</sup>
<b>OFFICE VISITS</b>	<b>\$20 copay</b>	<b>\$30 copay</b>	<b>40%<sup>(11)</sup> after deductible</b>
Lab And Imaging	No Charge	\$30 copay	40% <sup>(11)</sup> after deductible
<b>HOSPITAL CARE</b>	\$250 copay per admission	20% after \$250 deductible per admission <sup>(4)</sup>	40% after \$500 deductible per admission <sup>(4)</sup>
Emergency Room	\$50 copay <sup>(5)</sup> (waived if admitted to hospital)	\$50 copay <sup>(5)</sup> (waived if admitted to hospital)	Not covered
<b>RX BENEFIT<sup>(8)</sup> <sup>(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 (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	Not covered (if obtained at non-participating pharmacies)
<b>ADDITIONAL BENEFITS</b>			
Maternity / Prenatal Care <sup>(10)</sup>	\$5 copay	\$30 copay	40% <sup>(11)</sup> after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$1,500 / \$3,000	\$1,500 / \$4,500 <sup>(2)</sup>	\$3,000 / \$9,000 <sup>(2)</sup>
Maximum Benefit while insured	Unlimited	\$2,000,000 <sup>(3)</sup>	\$2,000,000 <sup>(3)</sup>
Outpatient Surgery	\$20 copay	\$30 copay	40% <sup>(11)</sup> after deductible
Home Health Care	No charge (up to 100 2-hour visits per calendar year, maximum 3 visits in one day)	20% after deductible (combined 100 visits per calendar year)	20% after deductible (combined 100 visits per calendar year)
Skilled Nursing Facility Care	\$250 copay per admission (up to 100 days per benefit period)	20% after \$250 deductible per admission (Combined 60-day limit per calendar year)	40% after \$500 deductible per admission (Combined 60-day limit per calendar year)
Ambulance Services	\$50 copay	\$50 copay	\$50 copay
Mental Health Services			
In the Medical Office (up to 20 visits per calendar year)	\$20 copay	\$30 copay	40% after deductible
In the Hospital	\$250 copay per admission (up to 30 days per calendar year)	Not covered	Not covered
Chemical Dependency Services			
In the Medical Office	\$20 copay	Not covered	Not covered
In the Hospital	\$250 copay per admission (detoxification only)	Not covered	Not covered

## POS 1000 Insurance Plan 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 1000			
MEDICAL BENEFITS	HMO	Participating Network Providers	Non-Participating Network Providers
	Member pays	Member pays	Member pays
Deductible: Individual / Family	No deductible	\$1,000 / \$3,000 <sup>(1)</sup>	\$1,000 / \$3,000 <sup>(1)</sup>
<b>OFFICE VISITS</b>	<b>\$25 copay</b>	<b>\$40 copay</b>	<b>30%<sup>(11)</sup> after deductible</b>
Lab And Imaging	No Charge	\$40 copay	30% <sup>(11)</sup> after deductible
<b>HOSPITAL CARE</b>	\$250 copay per admission	10% after \$250 deductible per admission <sup>(4)</sup>	30% after \$500 deductible per admission <sup>(4)</sup>
Emergency Room	\$50 copay <sup>(5)</sup> (waived if admitted to hospital)	\$50 copay <sup>(5)</sup> (waived if admitted to hospital)	Not covered
<b>RX BENEFIT<sup>(8)</sup> <sup>(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 (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	Not covered (if obtained at non-participating pharmacies)
<b>ADDITIONAL BENEFITS</b>			
Maternity / Prenatal Care <sup>(10)</sup>	\$5 copay	\$40 copay	30% <sup>(11)</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	\$25 copay	\$40 copay	30% <sup>(11)</sup> after deductible
Home Health Care	No charge (up to 100 2-hour visits per calendar year, maximum 3 visits in one day)	20% after deductible (combined 100 visits per calendar year)	20% after deductible (combined 100 visits per calendar year)
Skilled Nursing Facility Care	\$250 copay per admission (up to 100 days per benefit period)	10% after \$250 deductible per admission (Combined 60-day limit per calendar year)	30% after \$500 deductible per admission (Combined 60-day limit per calendar year)
Ambulance Services	\$50 copay	\$50 copay	\$50 copay
Mental Health Services			
In the Medical Office (up to 20 visits per calendar year)	\$25 copay	\$40 copay	30% after deductible
In the Hospital	\$250 copay per admission (up to 30 days per calendar year)	Not covered	Not covered
Chemical Dependency Services			
In the Medical Office	\$25 copay	Not covered	Not covered
In the Hospital	\$250 copay per admission (detoxification only)	Not covered	Not covered

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 copayments 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 Copayments; please refer to the Evidence of Coverage for detailed information about prescription drug Copayments.
- <sup>(10)</sup> Scheduled prenatal visits and the first postpartum visit.
- <sup>(11)</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.

## 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 500 Insurance Plan 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.

PPO 500		
MEDICAL BENEFITS	Participating Network Providers	Non-Participating Network Providers
	Member pays	Member pays
Deductible: Individual / Family	\$500/\$1,500 <sup>(1)</sup>	\$500/\$1,500 <sup>(1)</sup>
<b>OFFICE VISITS</b>	<b>\$20 copay<sup>(5)</sup></b>	<b>40% after deductible</b>
Lab And Imaging	20% – after deductible	40% – after deductible
<b>HOSPITAL CARE</b>	<b>20% after \$250 Deductible per admission<sup>(4)</sup></b>	<b>40% after \$500 Deductible per admission<sup>(4)</sup></b>
Emergency Room	20% after deductible	40% after deductible
<b>RX BENEFITS</b>		
Prescription – Generic	\$15 copay <sup>(7)</sup> (if obtained at participating pharmacies)	Not covered (if obtained at non-participating pharmacies)
Prescription – Brand	\$40 copay <sup>(7)</sup>	Not covered (if obtained at non-participating pharmacies)
<b>ADDITIONAL BENEFITS</b>		
Maternity/Prenatal Care	20% after deductible	40% after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$1,500 / \$4,500 <sup>(2)</sup>	\$4,500 / \$13,500 <sup>(2)</sup>
Maximum Benefit while insured	2,000,000 <sup>(3)</sup>	2,000,000 <sup>(3)</sup>
Outpatient Surgery	20% after deductible	40% after deductible
Home Health Care (up to 100 combined 2-hour visit per calendar Year)	20% <sup>(12)</sup> after deductible	20% <sup>(12)</sup> after deductible
Skilled Nursing Facility Care	20% after \$250 Deductible per admission <sup>(4)</sup> (60 days per calendar year)	40% after \$500 Deductible per admission <sup>(4)</sup> (60 days per calendar year)
Ambulance Services	40% <sup>(6)</sup> after deductible	40% <sup>(6)</sup> after deductible
Mental Health Services		
In the Medical Office – Severe mental illness <sup>(8)</sup>	\$20 copay <sup>(5)</sup>	40% after deductible
In the Hospital – Severe mental illness <sup>(8)</sup>	20% after \$250 deductible per admission <sup>(4)</sup>	40% after \$500 deductible per admission <sup>(4)</sup>
In the Medical Office – All other covered mental illness (up to 20 combined visits per calendar Year) <sup>(10)</sup>	20% after deductible	40% after deductible
In the Hospital – All other covered mental illness (up to 20 combined visits per calendar Year) <sup>(9)</sup>	20% after \$250 deductible per admission <sup>(4)</sup>	40% after \$500 deductible per admission <sup>(4)</sup>
Chemical Dependency Services <sup>(11)</sup>		
In the Medical Office	20% after deductible (20 visits per calendar year, maximum of \$10,000 per calendar year)	40% after deductible (20 visits per calendar year, maximum of \$10,000 per calendar year)
In the Hospital	20% after \$250 deductible per admission <sup>(4)</sup> (20 days per calendar year, maximum of \$10,000 per calendar year)	40% after \$500 deductible per admission <sup>(4)</sup> (20 days per calendar year, maximum of \$10,000 per calendar year)

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> Calendar Year Deductible amounts are combined for services provided by Participating Providers and Non-Participating Providers. 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 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 copayments 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> Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year combined for both Participating Providers and Non-Participating Providers.

<sup>(10)</sup> Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 outpatient days per calendar year combined for both Participating Providers and Non-Participating Providers.

<sup>(11)</sup> In addition to the specified day and visit limit noted above, benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of \$10,000 per calendar year and \$25,000 lifetime for services provided by Participating Providers and Non-Participating Providers.

<sup>(12)</sup> Combined maximum deductibles of \$50 per calendar year.

### 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.

## Indemnity Insurance Plan 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.

<b>MEDICAL BENEFITS</b>	<b>Indemnity Plan</b>
	Member pays
Deductible: Individual / Family	\$500 / \$1,500 <sup>(1)</sup>
<b>OFFICE VISITS</b>	<b>\$25 copay<sup>(3)</sup></b>
Lab And Imaging	30% after deductible
<b>HOSPITAL CARE</b>	<b>30% after \$500 deductible per admission<sup>(2)</sup></b>
Emergency Room	30% after deductible
<b>RX BENEFITS<sup>4</sup></b>	
Prescription – Generic	\$15 copay <sup>(5)</sup> (if obtained at participating pharmacies)
Prescription – Brand	\$40 copay (if obtained at participating pharmacies)
<b>ADDITIONAL BENEFITS</b>	
Maternity/Prenatal Care	30% after deductible
Annual Out-of-Pocket Maximum: Individual / Family	\$1,500 / \$4,500
Maximum Benefit while insured	\$2,000,000
Outpatient Surgery	30% after deductible
Home Health Care <sup>(9)</sup> (up to 100 combined 2-hour visits per calendar year)	20% after deductible
Skilled Nursing Facility Care	30% after \$500 deductible per admission <sup>(2)</sup> (60 days per calendar year)
Ambulance Services	30% <sup>(4)</sup> after deductible
Mental Health Services	
In the Medical Office – Severe mental illness	\$25 copay <sup>(3)</sup>
In the Hospital – Severe mental illness <sup>(6)</sup>	30% after \$500 deductible per admission <sup>(2)</sup>
In the Medical Office – All other covered mental illness <sup>(6)</sup>	30% after deductible <sup>(2)</sup> (20 visits per calendar year)
In the Hospital – All other covered mental illness <sup>(7)</sup>	30% after \$500 deductible per admission <sup>(2)</sup> (20 days per calendar year)
Chemical Dependency Services	
In the Medical Office <sup>(8)</sup>	30% after deductible (20 visits per calendar year, maximum of \$10,000 per calendar year)
In the Hospital <sup>(6)(7)</sup>	30% after \$500 deductible per admission <sup>(2)</sup> (20 days per calendar year, maximum of \$10,000 per calendar year)

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

### Footnotes

- <sup>(1)</sup> Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- <sup>(2)</sup> Inpatient deductibles neither contribute toward the Calendar Year Deductible nor do they contribute to the annual Out-of-Pocket Maximum.
- <sup>(3)</sup> Physician office visits, adult preventive screenings and exams, well-child preventive care visits, routine adult physical exams, pediatric visits, gynecological visits, and severe mental health visits and those treating the serious emotional disturbance of a child are subject to the per-visit copay noted in the chart. Copayments paid for such visits are neither subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Remaining charges for such visits will be covered at 100 percent of the Maximum Allowable Charge (MAC). The insured will be responsible for any charges that exceed MAC.
- <sup>(4)</sup> Medically Necessary Non-emergency ambulance coverage is limited to a maximum of \$2,000 per calendar year for all services.
- <sup>(5)</sup> MedCare Pharmacy copayments are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Prescriptions filled at a non-MedCare Pharmacy are not covered. Select prescription drugs are excluded from coverage.
- <sup>(6)</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>(7)</sup> Benefits for treatment of other covered Mental Illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year.
- <sup>(8)</sup> Benefits for treatment of other covered Mental Illnesses and alcohol and drug dependency are limited to 20 outpatient visits per calendar year.
- <sup>(9)</sup> Maximum deductible of \$50 per calendar year.

### <sup>‡</sup> Brand Name Prescription Drug and Generic Prescription Drug Rules

Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand name drug when patient requests brand name drug and a generic version is available.

### Out-of-Area 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 not Medically Necessary; in excess of the Maximum Allowable Charge; not available in the United States; for personal comfort; or not completed in accordance with the Physician's orders. Charges for nonemergency care in an emergency care setting 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 Covered Person 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 Covered Person'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 that 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. Care, Services or treatment of or in connection with craniomandibular or temporomandibular joint disorders, unless for Medically Necessary surgical treatment of the disorder; 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. 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 Covered Person's: commission of or attempt to commit a felony; engagement in an illegal occupation; being intoxicated or 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 medicine for smoking cessation. Services for which no Charge is normally made in the absence of insurance.

# Tools to Enroll

These are the tools available to help you enroll.

You will need to decide:

- If you want HMO, POS, PPO or Indemnity 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

**Kaiser Permanente Choice Solution**  
**Employee Enrollment Worksheet**

Division Code: 441104  
 Office #: 40015  
 Employer Zip Code: 90264

STARCO CODES FOR TELSELS  
 Office: 44-100  
 Resident: 20-100

Plan	Plan 10	Plan 30	Plan 50 (\$100 Deductible)	Indemnity Plan
<b>HMO Plan</b>				
Health Insurance Dental (HMO) Plan Vision Life Insurance Health Savings Health Reimbursement	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage
<b>POS &amp; PPO Plans</b>				
Health Insurance Dental (POS) Plan Vision Life Insurance Health Savings Health Reimbursement	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage

**Cost Summary Table:**

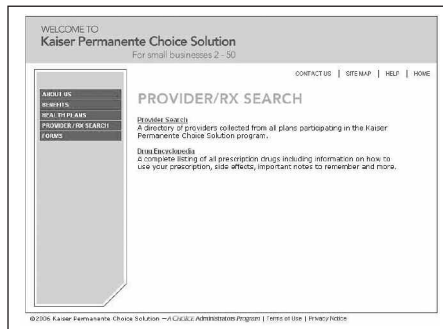
Plan	Monthly Cost	Annual Cost	Monthly Cost	Annual Cost
Plan 10	\$ 45.00	\$ 540.00	\$ 100.00	\$ 1,200.00
Plan 30	\$ 20.00	\$ 240.00	\$ 100.00	\$ 1,200.00
Plan 50 (\$100 Deductible)	\$ 0.00	\$ 0.00	\$ 100.00	\$ 1,200.00

## 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)



# Your Personalized Worksheet

Use your Personalized Worksheet to:

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

Verify your age and home Zip Code

Your employer's contribution appears here

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

**Kaiser Permanente Choice Solution**  
**Employee Enrollment Worksheet**

Effective Date: 04/01/06  
 Quote #: 600010  
 Employer Zip Code: 92868

**SAMPLE QUOTE FOR 10 LIVES**  
 Brown, S - Age 26  
 Residence Zip Code: 92868

HMO Plan	Plan 10	Plan 30	Plan 20 / \$1000 Deductible
<b>In-Network</b>	Yes	No Deductible	Yes
HMO Network Required	No Deductible	\$ 30 Copay	\$1,000/\$2,000
Deductible Ind/Family	\$ 10 Copay	\$250 per admission	\$ 20 Copay
Dr. Office Visits	\$100 Copay per day	\$ 10 Copay	80% after deductible
Hospital Services	\$ 20 Copay	\$100 Ded. - \$30 Copay	\$ 10 Copay
Rx Benefit (Generic)	\$ 20 Copay	\$2,000/\$4,000	\$100 Ded. - \$30 copay
Rx Benefit (Brand)	\$1,000/\$2,000		\$3,000/\$6,000
Out-Of-Pocket Maximum			

All eligible HMO benefits are covered In-Network only.

POS & PPO Plans	POS 500	POS 1000
<b>In-Network</b>	Yes - HMO	Yes - HMO
Network Required	No Deductible	No Deductible
Deductible Ind/Family	\$ 20 Copay	\$ 25 Copay
Dr. Office Visits	\$250 per admission	\$250 per admission
Hospital Services	\$ 10 Copay	\$ 10 Copay
Rx Benefit (Generic)	\$ 30 Copay	\$ 30 Copay
Rx Benefit (Brand)	\$ 40 Copay	\$ 40 Copay
Out-Of-Pocket Maximum	\$1,500/\$3,000	\$1,500/\$3,000

Out-Of-Network	POS 500	POS 1000
Deductible	\$500/\$1,000	\$1,000/\$3,000
Dr. Office Visits	60% after deductible	70% after deductible
Hospital Services	\$500 Ded per admission - 60%	\$500 Ded per admission - 70%
Rx Benefit (Generic)	Not Covered	Not Covered
Rx Benefit (Brand)	Not Covered	Not Covered
Out-Of-Pocket Maximum	\$3,000/\$9,000	\$4,500/\$13,500

**Indemnity Plan**

Network Not Required  
 \$500/\$1,500  
 \$25 Copay  
 \$500 Ded per admission-70%  
 \$15 Copay  
 \$40 Copay  
 \$1,500/\$4,500

**PPO Plan**

Yes  
 \$500/\$1,500  
 \$20 Copay  
 \$250 Ded per admission-80%  
 \$15 Copay  
 \$40 Copay  
 \$1,500/\$4,500

**PPO 500**

Yes  
 \$500/\$1,500  
 60% after deductible  
 \$500 Ded per admission-60%  
 Not Covered  
 Not Covered  
 \$4,500/\$13,500

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.

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

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.)

HMO Plans	Employee Only	Additional cost for Spouse Only	Additional cost for Child(ren) Only	Additional Cost for Family
Plan 10	\$ 44.00	\$ 149.00	\$ 185.00	\$ 377.00
Plan 30	\$ 22.00	\$ 132.00	\$ 164.00	\$ 335.00
Plan 20 / \$1000 Deductible	\$ 0.00	\$ 104.00	\$ 121.00	\$ 287.00
<b>POS Plans</b>				
POS 500	\$ 150.00	\$ 233.00	\$ 291.00	\$ 505.00
POS 1000	\$ 150.00	\$ 233.00	\$ 291.00	\$ 505.00
<b>PPO &amp; Indemnity Plans</b>				
PPO 500	\$ 150.00	\$ 233.00	\$ 291.00	\$ 505.00
Indemnity	\$ 150.00	\$ 233.00	\$ 291.00	\$ 505.00

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)

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

## Having a birthday?

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

# 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

**Medical / Dental / Life / Enrollment Application**

Use blue or black ink pen • Do not shrink this form

**A. Personal Information**

Name of Company: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_ Employee Job Title: \_\_\_\_\_ Effective Employment Date: \_\_\_\_\_

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

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

Employee First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ 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:  Plan 10  Plan 30  Plan 20/1000

POS:  POS 500  POS 1000

PPO:  PPO 500

INDEMNITY:  Indemnity Plan

**C. Enrollment Information (Complete this section ONLY if you are electing medical and/or dental for yourself or 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	<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	<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	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

\* Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent.

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

**DENTAL COVERAGE**

PPO 1500  PPO 1000  FFS 1500  FFS 1000

**LIFE INSURANCE**

Full Name of Beneficiary: \_\_\_\_\_ Relationship to Beneficiary: \_\_\_\_\_ Date of Birth for Beneficiary: \_\_\_\_\_

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

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

PLEASE SIGN AND DATE APPLICABLE SECTIONS ON THE REVERSE SIDE OF FORM

www.kpchoicesolution.com KP 0310 3/2006

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 to accept 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 dependent's 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 assignment of an appointment 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 my 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 patient 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 employer named on this application, myself and my dependents named on this application:

- I am either actively, presently 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 unmarried or not involved in a domestic partnership, and are financially dependent upon me or my spouse/domestic partner. 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 unmarried or not involved in a domestic partnership and are financially dependent upon my covered child per the IRS guidelines. My grandchildren are born to me 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 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 personal, business, or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover those losses.

- The representations 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.
- If I have READ, UNDERSTAND and ATTEST that myself and my dependents have all of the eligibility requirements listed on the second page of this application.

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

**Kaiser Foundation Health Plan Arbitration Agreement Applies to KTFP only, does not apply to Kaiser Permanente Insurance Company contracts.**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice, for premature 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 proceedings, 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 procedure is contained in the Certificate of Coverage.

By signing and submitting this application, I hereby agree to the above terms and conditions, and confirm that the information contained in this application is true and correct.

EMPLOYEE SIGN HERE FOR MEDICAL, DENTAL OR LIFE COVERAGE: \_\_\_\_\_ Date: \_\_\_\_\_

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

**COBRA Applicants:** Indicate Qualifying Event:  First-time COBRA enrollment  Death or longer illness  Medicare entitlement  Date of Qualifying Event: \_\_\_\_\_  
 COBRA  Cal-COBRA  Reduction of hours  Divorce/legal separation  Death of spouse

CHOICE Administrators Staff Use:  New Group-employee  New Hire  Open Enrollment Effective Date: \_\_\_\_\_

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**F. Full Time Student Verification**

If you wish to include a dependent between the ages of 19 and 24 under your medical and/or dental coverage, your dependent must meet the following eligibility requirements:

- Unmarried
- Financially dependent upon the Employee per IRS guidelines
- Enrolled full-time in an accredited secondary school or college (12 or more units)

This form must be completed and signed by the employee. Failure to complete and submit this verification may result in the denial of services/claims submitted on behalf of the dependent.

Employee Name: \_\_\_\_\_ Employer Group Number (if available): \_\_\_\_\_  
 Subscriber's Name: \_\_\_\_\_ Subscriber's Social Security Number: \_\_\_\_\_  
 Student's Name: \_\_\_\_\_ Name of School: \_\_\_\_\_ Date Enrolled: \_\_\_\_\_

I certify that my above-named dependent is an unmarried student. I hereby request continuation of my child's coverage under my group Health Plan with the understanding that I will notify Kaiser Foundation Health Plan immediately if my child marries or ceases to be a full-time student.

Date: \_\_\_\_\_ Signature of Subscriber: \_\_\_\_\_

**Medical / Dental Waiver**

Complete this form 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  Children/Grandchildren

2) Dental for:  Myself and dependents  Spouse/Domestic Partner  Children/Grandchildren

**C. Reason**

Required only if employee waiving coverage

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

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

**D. Signature**

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

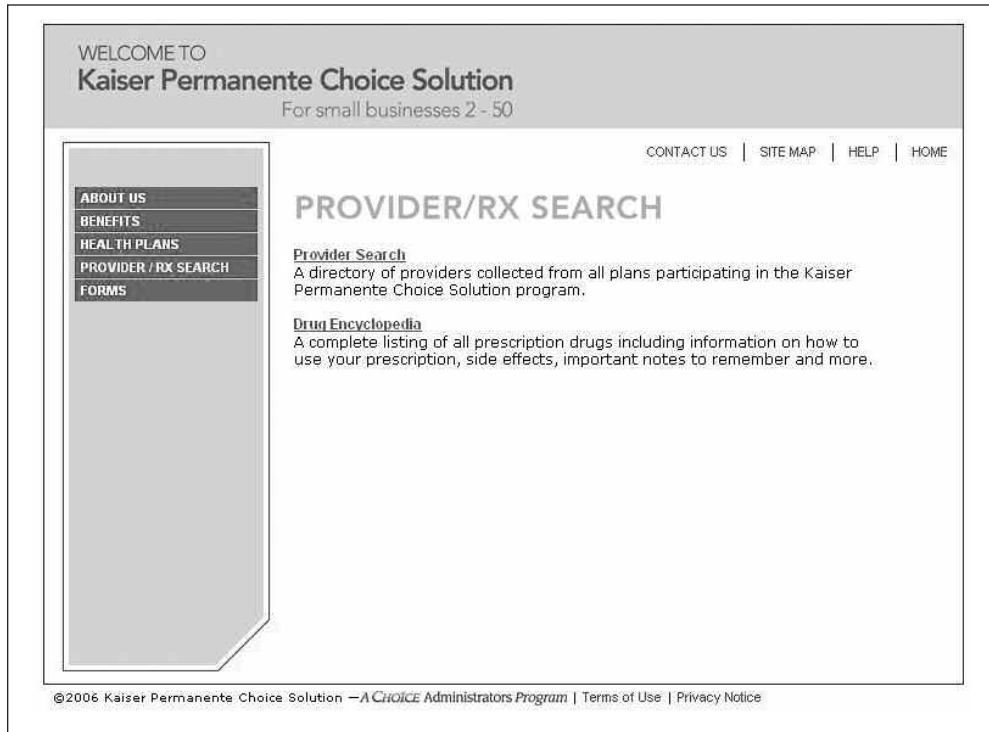
This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order or 3) Employee needs one of the following: A) that I cannot enroll under another employer-sponsored health plan at the time of initial eligibility; 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 contributions, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

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

www.kpchoicesolution.com KP 0312 3/2006

# 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.





# Summary

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

**Kaiser Permanente Choice Solution**  
**Employee Enrollment Worksheet**  
 Election Code: 041616  
 Date: 8/20/2016  
 Employer Zip Code: 92668  
 Revision: 8/16/2016

**Plan Selection**

Plan	Plan 10	Plan 20	Plan 20 / \$1000 Deductible	Indemnity Plan
Health Plan	Yes	Yes	Yes	Yes
Out-of-Pocket Max	\$10,000	\$10,000	\$10,000	\$10,000
Out-of-Pocket Max (Self)	\$5,000	\$5,000	\$5,000	\$5,000
Out-of-Pocket Max (Spouse)	\$5,000	\$5,000	\$5,000	\$5,000
Out-of-Pocket Max (Child)	\$5,000	\$5,000	\$5,000	\$5,000
Out-of-Pocket Max (Grandchild)	\$5,000	\$5,000	\$5,000	\$5,000

**Cost & Premiums**

Plan	Plan 10	Plan 20	Plan 20 / \$1000 Deductible	Indemnity Plan
Health Plan	Yes	Yes	Yes	Yes
Out-of-Pocket Max	\$10,000	\$10,000	\$10,000	\$10,000
Out-of-Pocket Max (Self)	\$5,000	\$5,000	\$5,000	\$5,000
Out-of-Pocket Max (Spouse)	\$5,000	\$5,000	\$5,000	\$5,000
Out-of-Pocket Max (Child)	\$5,000	\$5,000	\$5,000	\$5,000
Out-of-Pocket Max (Grandchild)	\$5,000	\$5,000	\$5,000	\$5,000

**Cost Comparison Table**

Plan	Monthly Cost	Annual Cost	Monthly Cost	Annual Cost
Plan 10	\$ 45.00	\$ 540.00	\$ 105.00	\$ 1,260.00
Plan 20	\$ 22.00	\$ 264.00	\$ 164.00	\$ 1,968.00
Plan 20 / \$1000 Deductible	\$ 0.00	\$ 0.00	\$ 121.00	\$ 1,452.00
POS Plan	\$ 100.00	\$ 1,200.00	\$ 201.00	\$ 2,412.00
PPO Plan	\$ 100.00	\$ 1,200.00	\$ 201.00	\$ 2,412.00
PPO & Indemnity Plan	\$ 100.00	\$ 1,200.00	\$ 201.00	\$ 2,412.00
Indemnity	\$ 100.00	\$ 1,200.00	\$ 201.00	\$ 2,412.00

- Fill out the **Enrollment Form** completely

**Kaiser Permanente Choice Solution**  
**Medical / Dental / Life / Enrollment Application**  
 Use Blue or Black Ink pen • Do not check this form

**A. Personal Information**

Name of Company: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_ Employee Job Title: \_\_\_\_\_ Current Employment Date: \_\_\_\_\_  
 Marital Status:  Married  Single  Other  Please specify on your application for enrollment. Do not put your name on this form for the employee or family.  
 Employee Last Name: \_\_\_\_\_ Employee Social Security Number: \_\_\_\_\_  
 Employee First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_ Mailing Address (if different from above): \_\_\_\_\_

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

Plan 10  Plan 20  Plan 20/1000  POS  POS 100  POS 1000  PPO  PPO 100  PPO 1000  Indemnity Plan

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

Employee	Spouse/Dependent Partner	Child/Grandchild	Child/Grandchild	Child/Grandchild
Last Name	<input type="checkbox"/> Same as you			
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	/ /	/ /	/ /	/ /
Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 Part?	<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

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

**DENTAL COVERAGE**  
 PPO 1000  PPO 1000  PPO 1000  PPO 1000

**LIFE INSURANCE**  
 Full Name of Beneficiary: \_\_\_\_\_ Relationship to Beneficiary: \_\_\_\_\_ Date of Birth for Beneficiary: \_\_\_\_\_

**PREMIUM ONLY PLAN (POP)**  
 I want my portion of eligible insurance premiums paid on a pre-tax basis

PLEASE SIGN AND DATE APPLICABLE SECTIONS ON THE REVERSE SIDE OF FORM  
 www.kpchoiceolution.com KP 0310 3/2006

# Important Reminders

- If HMO coverage, choose a PCP for each enrolled member

## Be sure to include the following on your application:

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

## 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 immediately upon termination of the marriage.

CHILDREN: Eligible children include: children born to you, your stepchildren or legal ward of, and adopted children by you or your spouse or your domestic partner.

GRANDCHILDREN: Can be covered as a dependent as long as the grandchild's parent is enrolled or may be covered as a legal ward as described above.

### **In order to be eligible, a Dependent child must be:**

- Dependent on the Employee for at least 50% of his/her economic support
- Unmarried
- Under age 19 (unless disabled, disability occurring prior to age 24) or a full time student and under age 24

Verification of eligibility will occur annually at the child's birthday

#### Disabled Dependents:

Children who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.

- 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 Member Services Dept. at (800) 580-9626 for further information and assistance.

## Coverage for Domestic Partner

Requirements:

The Employee and Partner must:

- Share a common residence
- Not be married under either a statutory or common law or part of a domestic partnership
- Be 18 years of age or older
- Share an intimate and committed relationship of mutual caring
- 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 immediately upon termination of the domestic partnership

Employee and Domestic Partner must also submit a signed affidavit attesting that the above conditions have been met.

## 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, co-payments 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

