Transparency in Coverage

This information is provided in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines and **applies only to Kaiser Permanente Insurance Company (KPIC) California Small Group Preferred Provider Organization (PPO) insurance plans.**

Out-of-Network Liability (Non-Participating Providers)

Overall, your out-of-pocket costs may be higher when you obtain care from a Non-Participating Provider instead of a Participating Provider. When you receive care from a Non-Participating Provider, you are also generally responsible for payment to the provider of amounts that are greater than the maximum allowable charge, which is called balance billing.

You may be required to pay the full amount you are billed when you receive care from a Non-Participating Provider. If so, you will need to submit a claim for reimbursement of covered charges. Please see **Enrollee Claim Submission** section below for more information.

The copayment or coinsurance required for emergency services from a Non-Participating Provider, however, will be the same copayment or coinsurance required for services from a Participating Provider. Please see the definition of Maximum Allowable Charge in your Certificate of Insurance (COI) for information about the amount payable for emergency services received from a Non-Participating Provider.

For a list of Participating Providers, please visit the MultiPlan/PHCS Provider Directory.

Enrollee Claim Submission

A claim is a request to an insurance company for payment of health care services. In most cases, when you receive care from a Participating Provider, you will not have to file a claim. Your provider completes and submits claim forms. Participating Providers are not allowed to balance bill.

However, you are responsible for paying amounts that are greater than the maximum allowable charge (balance bill) to Non-Participating Providers.

Claim Submission - Medical Claims

When you receive care from a Non-Participating Provider, you may be required to pay the full amount you are billed up front. In order to receive reimbursement for the covered amount of your claim, you will need to submit a claim form with an itemized bill for reimbursement. See claim form for further instructions.

If you file a claim:

- You have up to 365 calendar days from the date you received care to submit your claim.
- Kaiser Permanente Insurance Company will review the claim and decide what payment or reimbursement may be owed to you.
- Care must be medically necessary. Refer to your COI for more information.

You'll need specific information from your service provider. The Medical Claims section of your PPO Member Handbook has the steps to take to file a claim.

Claim Submission Address:

Kaiser Permanente Insurance Company
P.O. Box 261155
Plano, TX 75026
EDI Payer ID: KPIC1

Claim Submission – Pharmacy Claims

You generally won't need to submit a claim for prescription drugs. However, you may choose to pay for a prescription in full and request reimbursement if the MedImpact retail pharmacy doesn't honor your pharmacy benefit.

In order to receive reimbursement for prescription drug claims, you must use contracted pharmacies in the MedImpact network. For a list of MedImpact Pharmacies, please see the MedImpact Pharmacy Directory.

If you need to be reimbursed, please complete a Pharmacy claim form. Follow the directions on the claim form and fax it to MedImpact Healthcare Systems, Inc., at 858-549-1569.

Remember to fax copies of your receipts along with the claim form. You can get additional claim forms by calling our KPIC Customer Service Line at 1-800-788-0710.

Grace periods

A grace period is a time period when an insurer will not terminate the policy even though the policyholder did not pay the group's premium.

When an insurer pends a claim for non-payment of premium, that means no payment will be made to the provider until the policyholder's delinquent premium is paid in full.

KPIC does not pend claims for non-payment of premium during the grace period.

Retroactive Denials

A retroactive denial is the reversal of a claim we have already paid. In certain cases, a claim may be denied retroactively — for example, if you fail to pay your premium or you get services after your membership ends.

Retroactive denials may also occur due to payment of non-covered services. Make sure you talk to your provider about whether the service being performed is a covered benefit. Retroactive denials may also occur due to incorrect covered charges for services you received during your accumulation period and for non-participating provider billing errors.

In the event of a retroactive denial, you'll be financially responsible for the covered services you received. To ensure a claim is not retroactively denied, premiums must be paid on time. If you have questions about a claim that's been denied, please contact:

NTT DATA Services
P.O. Box 261130
Plano, TX 75026

Recoupment of Overpayments

The information below applies only to the Policyholder of a Group Insurance Policy. It does not apply to covered persons under a Group Policy.

If you believe you have paid too much for your premium and should receive a refund, please call the Member Service number on the back of your ID card.

In the event of termination by either KPIC or the Policyholder, KPIC will promptly return on a pro-rata basis the unearned premium paid, if any, and the Policyholder will be liable for all unpaid premiums for the period during which the Group Policy was in force with respect to any Covered Person whose coverage terminates. Such termination shall be without prejudice to any claim originating prior to the effective date of the termination.

Medical Authorization and Prior Authorization/Precertification

We must approve some services as medically necessary and medically appropriate before you can receive them. This is called prior authorization or precertification. For a complete list of services that require precertification, see your COI.

Precertification is not required for emergency admissions. You or your attending physician should notify the KPIC of the admission as soon as reasonably possible and no later than 24 hours following an emergency admission by calling the number on the back of your ID card.

You are responsible to obtain precertification. Request for precertification must be made by you or your attending physician prior to the commencement of any service or treatment. If you fail to obtain precertification, you incur the risk of receiving a penalty up to $500. The penalty does not apply toward your deductible or out-of-pocket maximum.

You or your doctor should call to ask for precertification at least 72 hours before you schedule services by calling 1-888-251-7052, Monday through Friday, 6 a.m. to 6 p.m., Pacific time.

A decision on a request for precertification for medical services will typically be made within 72 hours of us receiving the request for urgent cases or 5 days for non-urgent cases.

To learn more, review the Precertification section in your COI for details.

Drug Exception Timeframes and Enrollee Responsibilities

You can request an exception to obtain coverage of a drug that is not on the formulary by calling MedImpact at 1-800-788-2949.

Upon receipt of your exception request, MedImpact will notify you within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist, of the request approval or other outcome. Urgent circumstances exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health or ability to regain maximum function or when you are using a drug while undergoing a current course of treatment.

If a standard exception request is granted, coverage of the non-formulary drug will be granted for the duration of the prescription, including refills. If an exception based on urgent circumstances is granted, coverage of the non-formulary drug will be granted for the duration of the urgency.

If your exception request is denied, you have the right to appeal the denial. Please refer to the Claims and Appeals Procedures and Your Right to an Independent Medical Review section of your COI for more information.

Explanation of Benefits

Each time we process a claim submitted by you or your health care provider, we explain how we processed it in the form of an Explanation of Benefits (EOB).

The EOB is not a bill, it is an informational statement to keep you informed of any claims processed under your insurance plan. It simply explains how your benefits were applied to that each claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider.

In case of an Adverse Benefit Determination, the EOB will also include a notice that will tell you why we denied your claim and will include information regarding the mandatory appeals rights, including external review, that may be available to you.

After your claim is processed, you will receive the EOB that will detail what you need to pay and what the insurance plan will pay. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.

Coordination of Benefits

If you have health insurance coverage under more than one plan, the Coordination of Benefits (COB) process helps you make the most of your coverages to make sure you get the care you need. It determines the order in which different plans pay for services, which can make it easier to get and pay for care.

The plan that pays first is the primary plan. It’s responsible for paying first regardless of whether another plan covers some expenses so long as the care is covered. The secondary plan pays next. Based on how much the primary plan pays, it may reduce what it pays so the amounts from both plans don’t total more than the allowable expense for specific services. For more detailed information about COB, please see the Coordination of Benefits section of your COI.