Sincerely,

Kaiser Permanente
California Service Center
cc: [redacted]

Additional Required Regulatory Notice:

You are receiving this Notice of Cancellation because your coverage is being cancelled or not renewed because you have not paid your premium.

Even though you have not paid your premiums, you are being provided a "grace period" to allow you time to make your past due premiums payment(s) without losing your health care coverage.

"Grace period" means a period of at least 30 days beginning no sooner than the first day after the last day of paid coverage and lasts at least 30 days.

You may avoid losing your coverage if you pay the premium(s) you owe before the end of the grace period. If you do not pay the required premium amount by the end of the grace period, your coverage will be terminated effective the day after the last day of the grace period. Your grace period ends on December 1, 2016.

Coverage will continue during the grace period; however, you are still responsible to pay unpaid premiums and any copayments, coinsurance or deductible amounts required under the plan contract.

For information about individual health care coverage and health care subsidies that may be available to you, contact Covered California at (800) 300-1506 or TTY 711 or online at www.CoveredCa.com.

If you wish to end your coverage immediately, please contact Kaiser Permanente as soon as possible.

Right to Submit Request for Review of Cancellation, Rescission, or Nonrenewal of Your Plan Contract , Enrollment, or Subscription.

If you believe your plan coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Request for Review.

You have two options if you do not agree with the Kaiser Permanente's decision to cancel, rescind or not renew your health plan coverage.

Option (1) – You may submit a Request for Review to Kaiser Permanente.

- You may submit a Request for Review to Kaiser Permanente by calling 800-731-4661 or submitting a request at kp.org or by mailing your written Request for Review to PO Box 23219, San Diego CA 92193-3219.
- You may want to submit your Request for Review to Kaiser Permanente first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. Requests for Review should be submitted as soon as possible after you receive the Notice of Cancellation, Rescission, or Nonrenewal.
- Kaiser Permanente will resolve your Request for Review within three (3) days. If the plan upholds your cancellation, rescission or nonrenewal, it will immediately transmit your Request for Review to the Department of Managed Health Care

Option (2) – You may submit a Request for Review directly to the Department of Managed Health Care.

- You may submit a Request for Review directly to the Department of Managed Health Care without first submitting it to the Kaiser Permanente.
- Requests for Review by the Department of Managed Health Care may be submitted

STATE OF CALIFORNIA
Department of Managed Health Care

To: Department of Managed Health Care Help Center

Date:

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814
Fax: (916) 229-0465
www.healthhelp.ca.gov

RE: REQUEST FOR REVIEW OF CANCELLATION, RESCISSION, OR NONRENEWAL OF HEALTH CARE SERVICE PLAN BENEFITS

I request that the Director of the Department of Managed Health Care review the cancellation, rescission, or nonrenewal of the plan contract, enrollment, or subscription for health plan benefits pursuant to sections 1365 or 1389.21 of the Knox-Keene Health Care Service Plan Act of 1975, as follows:

1. Name of enrollee, subscriber, or group contract holder whose benefits were cancelled, rescinded, or not renewed:

_____
Full Name – First, Middle and Last Names

2. Name of subscriber, if different than item "1" above:

_____
Full Name – First Middle and Last Names

3. Name of plan:

_____

4. Subscriber or Enrollee Account or Identification Number:

_____

5. If applicable, the Group Identification Number:

_____

6. Date notice of cancellation was received (if known):

Date of Notice: _____

7. Attach copies of:

(a) The notice of cancellation sent by the plan.

(b) Any correspondence with the plan regarding the cancellation, rescission, or nonrenewal.

(c) Proof of payment for the last paid coverage period and date of payment.

8. Do you know why the plan cancelled, rescinded, or did not renew your coverage? If yes, please explain.

☐ Yes ☐ No

_____

_____

9. State why you believe the cancellation, rescission, or nonrenewal is wrong:

10. Explain why you believe the cause or causes for cancellation described in the notice of cancellation was wrong. Attach copies of any documents that help explain your position.

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11. Does the cancellation, rescission, or nonrenewal prevent you or any enrollee covered under the policy from receiving medically necessary health care services? If "yes," please explain:

☐ Yes ☐ No

12. Has the person named in item "11" above, whose health care benefits were cancelled, rescinded or not renewed, received any medical or health care since the cancellation, rescission or nonrenewal? If "yes," what services were received and how much did they cost?

☐ Yes ☐ No

Signature of Complainant: