KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
P.O. Box 629028
El Dorado Hills, CA 95762-9028

Spandana Ande
9669 GOLD COAST DR APT 83
SAN DIEGO, CA 92126-3950

Your IRS 1095-B Health Coverage Statement for 2022

You can get secure and convenient, access to your 1095-B online!

Sign up at kp.org/paperless1095B

February 09, 2023

Dear Spandana Ande,

The Affordable Care Act (ACA) requires taxpayers to prove they had health coverage in 2022 when they file their taxes for 2022. The enclosed IRS Form 1095-B reports proof of coverage. We are required to send you this form because you have a health plan with Kaiser Permanente.

What this form does and how you can use it:
This form serves to report proof that you and anyone you enrolled as a dependent on your Kaiser Permanente plan had a basic level of health coverage for the specific dates in 2022. This form only relates to health coverage you have through Kaiser Permanente. The 1095-B form lists individuals in your family who were enrolled in your coverage and shows their months of coverage. Use this information to help complete your tax return. You do not need to attach these forms to your tax return. For specific questions about your tax situation, please talk to your tax preparer.

Questions?
If you believe there's an error on your form or if you have any questions, please call us at **1-844-477-0450** (TTY **711**), Monday through Friday, from 8 a.m. to 6 p.m., and Saturday and Sunday (Pacific time), from 7 a.m. to 3 p.m. Or you can go to **kp.org/proofofcoverage** for more information. We're here to help you.

Sincerely,
Kaiser Permanente

This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000** and ask for language assistance.
Esta es información importante de Kaiser Permanente. Si necesita ayuda para comprender esta información, llame al **1-800-788-0616** y solicite asistencia de idiomas.
這是來自 Kaiser Permanente 的重要資訊。如果您在理解此資訊方面需要協助，請撥打電話到 **1-800-757-7585** 並要求語言協助。

564537582 September 2020

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Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

Do not attach to your tax return. Keep for your records.

Go to *www.irs.gov/Form1095B* for instructions and the latest information.

☐ VOID

☐ CORRECTED

OMB No. 1545-2252

2022

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name			2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
Spandana		Ande	***-**-3810	

4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
9669 GOLD COAST DR APT 83	SAN DIEGO	CA	92126

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . **B**

9 Reserved

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
POLARIS PHARMACEUTICALS INC			*****9361
12 Street address (including room or suite no.)	**13** City or town	**14** State or province	**15** Country and ZIP or foreign postal code
10675 Sorrento Valley Rd Ste 200	San Diego	CA	USA 92121

Part III Issuer or Other Coverage Provider (see instructions)

16 Name	17 Employer identification number (EIN)	18 Contact telephone number
KAISER FOUNDATION HEALTH PLAN, INC.	941340523	844-477-0450

19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code
One Kaiser Plaza 15L	Oakland	CA	United States of America US 94612

Part IV Covered Individuals (Enter the information for each covered individual.)

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
							Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	SPANDANA		ANDE	***-**-3810		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	X
24						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

If individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

TIP *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA) and the premium tax credit, see *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- **A.** Small Business Health Options Program (SHOP)
- **B.** Employer-sponsored coverage
- **C.** Government-sponsored program
- **D.** Individual market insurance
- **E.** Multiemployer plan
- **F.** Other designated minimum essential coverage
- **G.** Individual coverage health reimbursement arrangement (HRA)

TIP *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see* www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15. If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.