



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

Prashanth Kumar Mansani
5051 ALTON PKWY APT 182
IRVINE, CA 92604-8624

Your IRS 1095-B Health Coverage Statement for 2023

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

Sign up at kp.org/paperless1095B

February 12, 2024

Dear Prashanth Kumar Mansani,

The Affordable Care Act (ACA) requires taxpayers to prove they had health coverage in 2023 when they file their taxes for 2023. 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 2023. 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。

Your health plan coverage is issued by: Kaiser Permanente health plans around the country: California - Kaiser Foundation Health Plan, Inc.: Northern California - 1950 Franklin St., Oakland, CA 94612 • Southern California - 393 E. Walnut St., Pasadena, CA 91188 • Colorado - Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247 • Georgia - Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305; 404-364-7000 • Hawaii - Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813 • Maryland, Virginia, and Washington, D.C. - Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., Rockville, MD 20852 • Oregon and southwest Washington (Clark and Cowlitz counties) - Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Washington (except Clark, Cowlitz, and certain other counties) - Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 601 Union St., Suite 3100, Seattle, WA 98101 • Kaiser Permanente Insurance Company, 393 E. Walnut Street, Pasadena, CA 91188

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Form **1095-B**

Health Coverage

VOID

OMB No. 1545-2252

Department of the Treasury
Internal Revenue Service

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

CORRECTED

2023

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

Part I Responsible Individual

1 Name of responsible individual—First name, middle name, last name Prashanth Kumar		2 Social security number (SSN) or other TIN ***-**-8301	3 Date of birth (if SSN or other TIN is not available)
4 Street address (including apartment no.) 5051 ALTON PKWY APT 182		5 City or town IRVINE	6 State or province CA
		7 Country and ZIP or foreign postal code 92604	
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 ADP TOTAL SOURCE, INC/SCR			11 Employer identification number (EIN) *****6799
12 Street address (including room or suite no.) 10200 Sunset Dr	13 City or town Miami	14 State or province FL	15 Country and ZIP or foreign postal code 33173

Part III Issuer or Other Coverage Provider (see instructions)

16 Name KAISER FOUNDATION HEALTH PLAN, INC.		17 Employer identification number (EIN) 941340523	18 Contact telephone number 844-477-0450
19 Street address (including room or suite no.) One Kaiser Plaza 15L	20 City or town Oakland	21 State or province CA	22 Country and ZIP or foreign postal code 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 PRASHANTH KUMAR MANSANI	***-**-8301		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 ASHRITHA PABBA		1997-06-16	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)



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.