EMPLOYER C - CALIFORNIA

Large group administrative handbook

A guide to managing your account

IMPORTANT **CONTACT** INFORMATION

	Northern California	Southern California
California Service Center (CSC)	1-800-731-4661	1-800-731-4661
Fax enrollment change forms to:	1-858-614-3344	1-858-614-3345
Client Services Unit (CSU)	1-866-752-4737	1-866-752-4737
Member Service Contact Center	1-800-464-4000 1-800-777-1370 (TTY) 1-800-788-0616 (Spanish) 1-800-757-7585 (Chinese dialects)	1-800-464-4000 1-800-777-1370 (TTY) 1-800-788-0616 (Spanish) 1-800-757-7585 (Chinese dialects)
Web Support Team	1-800-893-2971, option 3 if outside of CA, 866-575-3562	1-800-893-2971, option 3 if outside of CA, 866-575-3562
KPIC Member Services	1-800-788-0710	1-800-788-0710
Self-Reporting Payment Address	Kaiser Foundation Health Plan, Inc. P.O. Box 80204 Los Angeles, CA 90080-0204	Kaiser Foundation Health Plan, Inc. P.O. Box 80204 Los Angeles, CA 90080-0204
Billed Payment Address	Kaiser Foundation Health Plan, Inc. File 5915 Los Angeles, CA 90074-5915	Kaiser Foundation Health Plan, Inc. File 5915 Los Angeles, CA 90074-5915
KPIC Payment Address	Kaiser Foundation Health Plan, Inc. File 54803 Los Angeles, CA 90074-4803	Kaiser Foundation Health Plan, Inc. File 54803 Los Angeles, CA 90074-4803
Membership Correspondence Address	Kaiser Foundation Health Plan, Inc. P.O. Box 23219 San Diego, CA 92193-3219	Kaiser Foundation Health Plan, Inc. P.O. Box 23758 San Diego, CA 92193-3758
Wire Transfers	Bank of America 100 West 33rd St., New York, NY 10001	Bank of America 100 West 33rd St., New York, NY 10001
• **Account name**	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
• **ABA number**	0260-0959-3	0260-0959-3
• **Account number**	12334-03557	12350-02104
ACH	Bank of America	Bank of America
• **Account name**	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
• **ABA number**	121000358	121000358
• **Account number**	12334-03557	12350-02104

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Welcome to the *Administrative Handbook for Large Accounts.* This handbook is your guide to administering Kaiser Permanente health benefits. Providing you with excellent customer service is always our priority. Think of this handbook as your "go-to guide."

In this handbook, you'll find important contact information, step-by-step reporting instructions, billing and enrollment information, a Q&A section, sample statements and forms, and a glossary of useful terms. You'll also find procedures for enrolling members in Medicare, COBRA, and Cal-COBRA.

The handbook has seven main sections:

Section 1. **Introduction—Welcome to the Administrative *Handbook***

Section 2. **Membership Reporting**

Section 3. **Accounting Procedures**

Section 4. **Medicare and Kaiser Permanente Senior Advantage (KPSA)**

Section 5. **COBRA and Cal-COBRA Procedures**

Section 6. **Questions and Answers**

Section 7. **Glossary**

If you can't find the information you need in this handbook, contact your Account Manager or the California Service Center (CSC).

Note: The information in this publication was accurate at the time of production. However, from time to time, new details become available after our release date. For the most current news, check with your Sales Executive or Account Manager.

SECTION 2—Membership Reporting

INTRODUCTION

Regular reporting of your Kaiser Permanente membership helps to ensure that your employees and their dependents are properly enrolled, that their coverage remains prepaid, and that newly enrolled employees and dependents receive their Kaiser Permanente identification cards.

The Kaiser Permanente California Service Center (CSC) manages the administration of customer accounts. The CSC provides contract administration and membership accounting services for all accounts. The CSC enrolls new employer groups and maintains your membership. In order for the CSC to keep accurate records of your membership, you must submit an enrollment/change form whenever there is a membership transaction (e.g., enrollment, family change, termination) on your account.

MEMBERSHIP REPORTING AND GUIDELINES

Processing your requests

All membership transaction requests (e.g., enrollment, family change, termination) for new and existing members must be submitted on an enrollment/change form, or via the Internet on our Online Account Services website, **cas.kp.org** or by an electronic media file. Membership changes cannot be accepted over the telephone.

Open enrollment

Enrollment/change information must be completed and signed by your employee at the time of the open enrollment period set forth in your contract. Delaying this process may cause members to be rejected for coverage. Eligible employees and their eligible dependents who don't enroll when they are initially eligible are subject to the exceptions listed in the *Schedule of Coverage* and *Certificate of Insurance* and may only enroll during their next open enrollment period or qualifying event.

BINDING ARBITRATION

Kaiser Foundation Health Plan, Inc., (Health Plan) has used binding arbitration to settle member disputes since 1971. The California Health & Safety Code requires health plans that use binding arbitration to disclose information to the individual enrollee at the time of enrollment. Failure to notify the enrollee by prominent disclosure at the time of enrollment and obtain their written signature immediately beneath this disclosure would be grounds for a Court to deny a motion by Health Plan to compel arbitration.

Note: Kaiser Permanente Insurance Company also uses binding arbitration for the Point of Service (POS) Plan—Tier 1 only.

Regulations

California Health & Safety Code (H&SC) Article 4, 1363.1

Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:

1. The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.
2. The disclosure shall appear as a separate article in the agreement issues to the employer group or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.
3. The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.
4. In any contract or enrollment agreement for a health care service plan, the disclosure required by this section shall be displayed immediately before the signature line provided for the representative of the group contracting with health care service plan and immediately before the signature line provided for the individual enrolling in the health care service plan.

Enrollment Application Requirements

All employer groups must use enrollment application forms that are provided by Health Plan. If you'd like to use a different form or system for enrolling members, the Health Plan's approval of the form or system must be obtained. Other forms and systems include a "universal" enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling members (see below for further details), including disclosure of binding arbitration in accord with Section 1363.1 of the California Health & Safety Code and other applicable law. Your Account Manager can provide the most current requirements for enrollment application forms and systems.

Health Plan Requirements for Enrolling Members:

1. **Universal Enrollment Forms—**All universal (client created) enrollment forms must be approved by Employer &TPA Services, Arbitration Team.
2. **Electronic (Online) and Telephonic Enrollments**—Health Plan requires employer groups that use electronic (online) enrollment or telephonic (IVR) enrollment methods must also incorporate the appropriate arbitration agreement disclosure and obtain agreement from the enrollee. This process must be approved by Employer & TPA Services, Arbitration Team.

To contact the Arbitration Team, email them at CA-Arbitration@kp.org

3. **Client Online Enrollments**—Employer groups, brokers, and TPAs (the client) that gather enrollee information on an enrollment vehicle of their own or a contractor's design—rather than use a current KP enrollment form for the purpose of uploading enrollment information to Kaiser Permanente (including via Online Account Services) are required to obtain Employer & TPA Services, Arbitration Team approval of their enrollment vehicle before use.

Client Online Enrollments

Our customers, brokers, and third-party administrators (the client) that gather enrollee information on an enrollment website of their own or a contractor's design—rather than use a current KP enrollment form—for the purpose of uploading enrollment information to Kaiser Permanente (including via Online Account Services) are required to obtain Employer & TPA Services, Arbitration Team approval of their enrollment site before use. The enrollment website must prominently display an arbitration disclosure in 10-point **bold font** in the form of the **KFHP & KPIC Arbitration Agreement,** (blended notice) with underlined heading, when a KPIC POS Plan is used/not used, or the **KFHP Arbitration Agreement** with underlined heading, when there is no KPIC POS Plan. The enrollee must then be instructed to type in an electronic signature or to "click" on an *I Accept* or similar "button" to signify the enrollee's signature to and acceptance of the arbitration agreement. The typed signature or button must be positioned on the same page immediately beneath the Agreement.

Online California Arbitration Management System (CAMS)

To make it easier for you to comply with state requirements, Kaiser Permanente has updated the process for gathering signatures on arbitration notices. Kaiser Permanente developed a Web application to electronically capture Arbitration agreements at the point of enrollment—the California Arbitration Management System (CAMS). The questions and answers found in *Section 6—Questions & Answers* will help you respond to employee inquiries about this process.

Record Retention—How Long?

All enrollment vehicles—paper enrollment forms, online screen images, IVR scripts—must be archived for an indefinite period of time. Access may be required more than 10 years after the initial medical event.

Review and Approval of Universal Enrollment Forms, Online, and IVR Scripts by HPRS/PDS:

As part of your annual renewal process, your Account Manager will verify your method of enrollment and work with you to ensure it follows Kaiser Permanente's

requirements. In cases outside of your annual review, please keep your Account Manager engaged in all scenarios regarding the arbitration disclosure and methods of enrollment.

Please contact your Kaiser Permanente Account Manager to acquire the approval of Universal Enrollment Forms.

MEMBERSHIP ADMINISTRATION

Qualifying events

There are circumstances in which employees other than new hires become newly eligible for coverage. These circumstances are called "qualifying events." The same qualifying events must apply to all health plans offered by the employer. These events are:

- Increase in an employee's hours so that he or she meets your requirement for medical plan eligibility.
- When an employee covered under a different plan moves out of that plan's service area.
- When a dependent loses coverage elsewhere.
- Marriage.
- Addition of a domestic partner.
- Divorce or termination of a domestic partnership.
- Birth.
- Adoption of a child.
- Death of a spouse, domestic partner, or dependent.
- A significant change in the health coverage of the employee, spouse, or domestic partner because of a change in the spouse's or domestic partner's employment.
- Court order.
- When an employee moves from a job category in which Kaiser Permanente Insurance Company (KPIC) is not offered into a job category in which KPIC is offered.
- When an employee who previously lived outside the Kaiser Permanente service area subsequently moves into our service area (This applies to POS members only).

REMINDER

When qualifying events occur, the enrollee doesn't need to wait for open enrollment to enroll.

Medical record numbers (MRNs)

Whenever possible, medical record numbers (MRNs) should be included on all documents and correspondence sent to Kaiser Permanente.

Duplicate MRNs

MRNs are unique and individuals must keep their same number whenever they enroll in a Kaiser Permanente or KPIC product. Multiple MRNs may lead to duplicate or incomplete clinical records and may result in delays when seeking medical care. It is very important that your employees complete the space indicating whether they have ever been a Kaiser Permanente member in the past and listing any other names under which they may have been enrolled. This allows us to issue the same MRN to the member.

Disabled dependent certification

If Kaiser Permanente performs the disability certification process for overage dependents as covered in your Group Agreement, the subscriber/employee must:

- Notify the benefits administrator.
- Contact Kaiser Permanente at **1-800-731-4661 to** request disability certification application.
- Complete and submit a disability certification application to the address indicated on the form.

If you perform your own disability certification, report the overage dependent to Kaiser Permanente as a disabled dependent using the existing enrollment procedures set forth in your Group Agreement. If Kaiser Permanente currently performs the disability certification process, and you wish to assume this responsibility, please contact your account management team for more information.

Live/work provision

Kaiser Permanente allows individuals who live or work in our service area to enroll in Kaiser Permanente. The live/work provision applies to all non-Medicare subscribers, including COBRA subscribers. Live/work doesn't apply to Kaiser Permanente Senior Advantage. The customer/employer determines whether to offer the live/work provision. When you send us an enrollment/change form for someone outside our service area, we'll enroll the individual. We'll assume that you have verified eligibility, ensuring that the person lives or works inside our service area in accordance with your Group Agreement.

REMINDER

Members who live outside our service area must receive covered services from Plan providers inside the service area, except as otherwise described in the *Evidence of Coverage*. Also, in accordance with the Evidence of Coverage, we can't enroll persons who live in a Kaiser Permanente region outside California.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Certification of Creditable Coverage be issued to terminated members of Kaiser Permanente. The certification document health care coverage during Kaiser Permanente membership and are the primary means that individuals use to prove prior creditable coverage when seeking new group coverage or coverage in the individual market.

Employee notification

Certificates are issued the first week of each month regarding employees who were terminated in the previous month. Certificates are mailed to the member's home address.

REMINDER

Members with an active status are also entitled to receive a HIPAA Certificate of Creditable Coverage within a reasonable time following their submission of a written request to Health Plan.

Certificate administration

Kaiser Permanente has elected to issue the Certificates of Creditable Coverage directly to the affected individuals, although the responsibility rests equally on the employer and the Health Plan. The employer may request that Kaiser Permanente suppress the certificates by signing our letter of indemnification, whereupon the employer accepts the responsibility of issuance.

1095-B
Kaiser Permanente is required to send Form 1095-B to subscribers so they can show proof of health coverage when they file their federal tax return. Form 1095-B serves as proof that subscribers and anyone they enrolled as a dependent on their Kaiser Permanente plan had minimum essential coverage for the listed specific dates in the current tax year. The subscriber may use the information on Form 1095-B to populate their health coverage history on their federal tax return.

Enrollment/Change Form

The enrollment/change form is a legal document and must be treated as such. This form identifies all required information needed to process membership requests.

- Enrollments will not be processed until a completed enrollment/change form is received. Review all enrollment forms for completeness and accuracy before submission to help ensure that all enrollment requests are processed.
- All requests for enrollment must be dated and signed by the subscriber.
- Completed forms should be mailed or faxed to the CSC at the appropriate address or fax number found on the Important Contacts page of this handbook.
- If forms are faxed, it's not necessary to mail the original request.

Completing the enrollment/change form

Forms submitted without complete information or your employee's signature may delay enrollment. Refer to the back of the forms for detailed instructions.

Mandatory fields

The items listed below show the sections on the enrollment/change form that must be completed for your membership requests to be processed:

Subscribers

- Last and first names
- Address
- Date of birth
- Gender
- Group ID
- Enrollment unit
- Signature date
- Event date
- Enrollment reason
- Social Security number
- Previous Kaiser Permanente MRN

Dependents

- Last and first names
- Address
- Date of birth
- Gender
- Group ID
- Enrollment unit
- Signature date
- Event date
- Dependent role
- Social Security number
- Previous Kaiser Permanente MRN

Avoiding delays

To prevent delays in processing, completed enrollment/change forms should be submitted to the CSC throughout the month—as you receive them from your employees. The most common reasons for delays in processing enrollments are:

- Missing or inaccurate customer numbers, enrollment/billing unit numbers, and/or medical record numbers.
- Missing or incomplete birth dates for subscribers and/or dependents.
- Missing or incomplete Social Security numbers for subscribers and/or dependents.
- Missing or incomplete addresses.
- Missing signature of the subscriber.
- Missing date of hire or qualifying event.
- For new hires, the date of hire not meeting the eligibility rules set by the employer.
- Receiving multiple copies of the same request.

Retroactivity

Our retroactivity policy for any membership change is the current month plus or minus two months. Kaiser Permanente allows employers to enroll or terminate members within this time frame (except for Kaiser Permanente Senior Advantage members).
To keep retroactive adjustments to a minimum, submit your completed enrollment/change forms as soon as you receive them from your employees and report any employee terminations on the subscriber termination and transfer form.

Member enrollments

When the CSC processes enrollments, the information on the form is compared to the eligibility provisions in your contract. Eligible employees who wish to enroll must complete the enrollment/change form. This form provides us with the information we need to enroll your employees (subscribers) and their eligible family members (dependents). Enrollment/change forms should be signed and submitted within 31 days of the qualifying event.

Your employees must retain the bottom copy of this form for identification until they receive their permanent ID card. Please provide your employees with your customer number and their effective date of coverage.

Family account changes

An enrollment/change form must be completed by your employee whenever a dependent is added or deleted. The form must also be completed to report other family changes, such as a new address or name change.

Dependent enrollments

All requests for enrollment of dependents must include the family relationship. Verify that the information is complete for each dependent being enrolled. The social security number, date of birth, enrollment reason, and event date must be included on the form. Enrollment/Change Forms for adding dependents must be signed by the subscriber and submitted to their employer within 31 days of the qualifying event.

Terminations

Report employee terminations by filling out a Kaiser Permanente Subscriber Termination and Transfer Form. The employer must notify Kaiser Permanente of member (i.e., subscriber and/or dependent) terminations and transfers within the standard retroactivity policy (except for Kaiser Permanente Senior Advantage).

The employee name, MRN, and employment termination date are required to remove the employee from your monthly bill. The CSC will then terminate the employee/dependent determined by the eligibility end date set forth in your contract.

Subscriber terminations

When a subscriber is terminated, the entire family account is terminated.

- Complete the termination form and submit it to the CSC.
- The minimum fields required to report an employee termination are employee name, MRN, and termination date.

Dependent terminations

The enrollment/change form must be completed and signed by your employee when dependents are deleted from his or her account. The CSC will terminate the dependent's membership based on the eligibility rules for terminations set forth in your contract.

An enrollment/change form can be submitted by the employer to delete an overage dependent. However, our accounting system will automatically terminate the dependent's membership based on the eligibility provision of your contract.

Transfers

Member transfers may be made during open enrollment or during qualifying events. All member transfers must be reported by filling out a new termination and transfer form representing the enrollment to the new billing unit. Be sure to indicate the member's new billing unit number. Membership and dues must be current before transferring from one billing unit to another and vice versa; otherwise, the standard retroactivity policy will apply.

The employer must notify Kaiser Permanente of member (i.e., subscriber and/or dependent) terminations and transfers within the standard retroactivity policy (except for Kaiser Permanente Senior Advantage).

REMINDER

A dependent who is already enrolled, is not a student or a disabled dependent, and reaches the maximum age for unmarried dependents (per your eligibility provisions) must be deleted from the employee's account.

Online account administration—Online Account Services (OAS)

Our Online Account Services will enable you to:

- Access your health plan account quickly without making a phone call.
- Keep your bills as current as possible by allowing you to enter enrollments and terminations at any time.
- Have more control by maintaining your membership information directly on our systems.
- Pay your bill quickly and easily online with a one-time payment or monthly debits.
- Work according to your schedule, without being limited to Kaiser Permanente service hours.
- Download your monthly bill into a PDF.
- Based on your access, you can view your current contract, evidence of coverage documents and your Summary of Benefits and Coverage (SBC's)

If you haven't signed up for our Online Account Services and would like to enjoy these benefits, please visit us at cas.kp.org. At the site, you can complete and submit the access request form. You'll receive an access code that can be used with your registration to access your group data. Once registered, you'll be able to view your bill, and you'll find step-by-step instructions for using the online account services.

If you have any questions about the site and need assistance with getting access, please call 1-800-893-2971, Option 3 if in California or 866-575-3562 outside of California. Monday through Friday, 8 a.m. to 5 p.m. (Pacific Time)

Electronic media Reporting

If you currently report to Kaiser Permanente via an electronic media file, please be sure to use only this method when submitting membership changes and/or enrollments.

If you are interested in reporting eligibility and/or premium information using an electronic media file or you have any questions related to your file feed, please contact our EFI Liaison at CSC-EFI-EM-Liasion@kp.org.

Enrollment/Change Form

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name | Hire date (mm/dd/yyyy)

Group number | Enrollment unit | Effective enrollment/ change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON *(see Change Table for assistance)* New group: ☐ Yes ☐ No

☐ New Hire *(complete sections A, B, C, D)* ☐ Open Enrollment *(complete sections A, B, C, D)*

Health Plan *(Check one)* ☐ HMO Plan ☐ Deductible Plan ☐ Other

☐ Loss of Other Coverage *(complete sections A, B, C, D)* ☐ Other *(please specify)*

☐ Name Change *(complete sections A, B, C, D)* From: To:

Event Date (mm/dd/yyyy)

B. EMPLOYEE Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. *(if known)* | Social Security No.

Name (Last, First, MI) | Birth Date (mm/dd/yyyy) | Gender ☐ M ☐ F

Home Address | City | State | ZIP

Work Phone | Home Phone | Email

Ethnicity | Preferred Language

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

☐ Add ☐ Delete ☐ Spouse ☐ Domestic partner Gender ☐ M ☐ F | Social Security No.

Spouse/domestic partner name: | Birth Date (mm/dd/yyyy)

Former last name *(if any)*: | Medical Record No.

☐ Add ☐ Delete ☐ Child ☐ Student Gender ☐ M ☐ F | Social Security No.

Dependent name: | Birth Date (mm/dd/yyyy)

Relationship: | Medical Record No.

☐ Add ☐ Delete ☐ Child ☐ Student Gender ☐ M ☐ F | Social Security No.

Dependent name: | Birth Date (mm/dd/yyyy)

Relationship: | Medical Record No.

☐ Add ☐ Delete ☐ Child ☐ Student Gender ☐ M ☐ F | Social Security No.

Dependent name: | Birth Date (mm/dd/yyyy)

Relationship: | Medical Record No.

Do any of dependents above live at another address? ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC),* any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises 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 process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage and in the Certificate of Insurance.

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2), the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3), the KPIC Dental Plans.

Signature Required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) | Date

KAISER PERMANENTE®

88350
Revision date 09/2013

Cobra Enrollment Form

KAISER PERMANENTE®

COBRA Enrollment Form

This enrollment form must not be submitted to Kaiser Permanente. Ask your former employer where you should send this form. Complete all fields or you may have a delay in your enrollment. Please print or type in black or dark blue ink only.

TO BE COMPLETED BY EMPLOYER

Purchaser/Enrollment Unit Number	Employer	Employer Signature/Date

Enrollment Information

Please check the reason for enrollment and complete the maximum months of coverage. NOTE: If requesting a transfer of an existing COBRA account from another carrier to Kaiser Permanente, you must indicate the qualifying event for the initial COBRA enrollment.

Reason for COBRA Enrollment

- ☐ Date of termination of employment: MO ____ DAY ____ YEAR ____
- ☐ Date of reduction of work hours: MO ____ DAY ____ YEAR ____
- ☐ Loss of spousal or dependent status: Effective Date of Loss: MO ____ DAY ____ YEAR ____
  Reason for loss: ○ Marriage ○ Divorce or legal separation ○ Death of subscriber ○ Reached maximum age ____
  ○ Subscriber's Medicare entitlement ○ Other ____
- ☐ Transfer of existing COBRA account from another carrier to Kaiser Permanente
  Carrier's Name & Telephone Number ____
  Policy Number ____ Policy Term Date ____
  Original initial COBRA enrollment reason ____
  Original initial COBRA coverage start date ____

Maximum months of coverage ____

Additional Enrollment Information

- ☐ Qualified beneficiary on the account is disabled pursuant to US Social Security Act
- ☐ Applying for Health Care Tax Credit (TAA/HCTC) through the Federal Government. (Please attach a copy of your potential eligibility letter.)

TO BE COMPLETED BY EMPLOYEE

Please list all members to be enrolled in the account. With the exception of annual Open Enrollments or Special Enrollments due to HIPAA, only a spouse and dependent children included in the prior group coverage may be enrolled as part of your COBRA account. (Attach additional sheet, if needed.)

Subscriber Information

Name: (Last/First/MI)	Social Security number	Date of birth	Gender
			M☐ F☐

Address: (Street/City/State/ZIP)

Day phone number	Alternate phone number	Email address (for enrollment purpose only)

During this employment was Kaiser Permanente your group coverage? ☐ Yes ☐ No

Family Information

	Name: (Last/First/MI)	Role	Social Security number	Date of birth	Gender
Spouse or domestic partner (if eligible)		○ Spouse ○ Domestic partner			M☐ F☐
Dependent		○ Child ○ Student			M☐ F☐
Dependent		○ Child ○ Student			M☐ F☐

I, on behalf of myself and my family members listed on this Form, if any, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations and other terms and conditions of the Group health plan documents, including the Evidence of Coverage. I have reviewed the statements on this form and they are true and correct. The Health Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in this Form.

Kaiser Foundation Health Plan, Inc. and Kaiser Permanente Insurance Company Arbitration Agreement*: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises 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 process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage* and in the *Certificate of Insurance*.

** Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.*

Signature Required for all Kaiser Permanente Plans
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

Date

Term and Transfer Form

KAISER PERMANENTE®

Subscriber Termination and Transfer Form

Use this form for billed purchasers to request subscriber/account terminations and/or subscriber/account transfers from one enrollment unit to another within the same purchaser ID and region. **Do not use this form for new subscriber enrollments and/or dependent additions or terminations.**

Purchaser information

Today's date _____

Purchaser name _____

Purchaser/enrollment unit number _____ – _____

Billing contact name *(please print)* _____ Telephone number ( ) _____

E-mail address *(optional)* _____ Fax number ( ) _____

☐ Check here if billing contact information is new

Termination or transfer requests *(refer to the processing rules on page 2)*

Subscriber name	Subscriber medical record number	Subscriber Social Security number	Termination or transfer effective date *(see page 2)*	Termination or transfer reason code *(select from table below)*	Indicate new enrollment unit *(required for transfers only)*
				1-Employn	
				1-Employn	
				1-Employn	
				1-Employn	

Termination reason codes

1–Employment terminated	3–Leave of absence	5–Military duty	7–Enrolled in error	9–Subscriber requested
2–Subscriber retired	4–Layoff	6–Subscriber deceased	8–Loss of disabled status	

Transfer reason codes

(refer to page 2 for additional information)

10–Open enrollment plan changes	**13–Employment status change:** • Start or termination of employment of the employee's spouse • Start of, or return from, leave of absence • Change from salaried to hourly or vice versa • Change from part-time to full-time or vice versa • Employee retirement • Strike or lockout • Significant change in health coverage of the employee or spouse attributable to the spouse's employment	**14–Marital status change:†** • Marriage • Death of employee's spouse • Divorce or annulment • Legal separation	**15–Dependent status change:†** • Birth • Adoption or placement for adoption • Death of dependent child • Newly eligible dependents due to employer change in eligibility rules • Dependent loss of eligibility due to age, student status, or marriage
11–Change in geographic service area*			
12–Loss of coverage: • Spouse or dependent loss of coverage • Reaching lifetime maximum			

*For transfer reason code 11, submit a completed Group Enrollment/Change Form signed by the subscriber providing the new address.
†For transfer reason codes 14 or 15, submit a completed Group Enrollment/Change Form signed by the subscriber if adding or removing a dependent(s) from the subscriber's account. Refer to page 2 for additional information.

PAYMENT REMITTANCE AND REPORTING RULES

As the employer, you are responsible for the reconciliation of your account. Complying with the following information will expedite the time it takes you to review and reconcile your account information each month. Your contract requires you to provide membership information regularly and to pay the monthly coverage dues for your enrolled members no later than the payment due date. Employers who fail to make their payment by the due date risk delinquency actions and may be subject to a late payment charge or termination from the health plan.

The monthly bill you receive is associated to a specific activity period. Membership transactions processed after the billing cut off for your activity period will appear on your next bill. Please be sure to pay the current and retroactive dues on your invoice, as well as any previous unpaid balances, in order to maintain accurate billing.

Customer number and enrollment/billing unit number

You must include your customer and enrollment/billing unit numbers on all documents and payments you submit. This is particularly important if you have multiple contracts or billing units. These numbers on the appropriate forms allow for timely and accurate processing of your membership requests and payment allocation.

Delinquency

Be sure to remit your payment before your due date. Remember to allow for mailing and processing time. Employers are subject to delinquency actions for unpaid dues. Unresolved delinquencies may result in automatic termination of your account. Discuss any billing cycle, coverage period, or delinquency rule questions with your Kaiser Permanente representative.

Late Payment charge policy

- Kaiser Permanente is a prepaid health plan. Our standard Group Agreement requires customers to pay by the first day of the coverage month. If a customer pays after the first day of the coverage month, the dues may include an additional charge. The purpose of this charge is to compensate Kaiser Permanente for the costs of a late payment and any associated administrative expenses.
- Our Group Agreement states that we may include a charge if payment is received after the first day of the coverage month. For administrative ease, we define "late" for all large group employers as occurring when Kaiser Permanente or our assigned financial institution receives payment after the close of business on the 15th day of the coverage month (if the 15th falls on a weekend or federal holiday, then after the first business day following the 15th).

REMINDER

Important things to remember when sending your payment:

- Please do not staple your check to the remittance advice.
- Please do not send membership correspondence with your check. Membership correspondence should be sent to the appropriate areas indicated on the Important Contacts page of this handbook.
- The employer is responsible for reviewing the bill and verifying that all current and retroactive transactions are correct.

- Eligibility for the Late Payment Charge is assessed annually.
- When the customer has paid 13 or more half-months late in a 12-month period, the customer may be assessed a Late Payment Charge.

Returned checks

Any check that is returned to us from the bank for non-sufficient funds (NSF) will result in a charge to the employer. This charge will be added to the balance of your account.

Remitting your monthly payment

Payments may be remitted for the Health Plan coverage dues by check, wire transfer, automated clearing house (ACH) payment, or via our online banking for employers with access to our online account services.

To remit your monthly payment:

PAYING BY CHECK

1. Prepare a check made payable to Kaiser Foundation Health Plan, Inc. for the total amount due.
2. Write the billing/enrollment unit number on your check.
3. Mail your check with the remittance advice (lower portion of the first page of your bill) before the due date using the envelope provided with your billing statement. Remember to allow for mailing and processing time. Refer to the Important Contacts page of this handbook for mailing information.

Paying online through our Online Account Services website

If you are currently a registered user of our Online Account Services website, you have the ability to view and pay your monthly bill online. You need to establish banking information in order to set up online bill pay functionality. There are two ways for you to pay your bill online:

1. Auto debit is a direct debit function. Each month, total amount due on your billing statement will automatically be withdrawn from your account the day before your bill due date.
2. Pay by Internet is a one-time payment. You will be notified via email when your bill is ready to be viewed. You may then log on to the Online Account Services website to make a one-time payment.

If you haven't signed up for our Online Account Services and would like to learn more, call **1-800-893-2971**, Option 3 if in California or 866-575-3562 outside of California. You may also email them at csc-sd-cas-web-support@kp.org. Monday through Friday, 8 a.m. to 5 p.m., or visit us at **cas.kp.org** and select the "Take our virtual tour" link.

Paying by automated clearing house (ACH) payment or wire transfer

You may make electronic payments through ACH payments and wire transfers. ACH payments cost less and are processed within one business day; wire transfers settle on the same day.

To set up ACH payments:

Request that your bank schedule ACH payments and give the following information:

ACH payments	For accounts in Northern California	For accounts in Southern California
Beneficiary name	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
Bank name	Bank of America	Bank of America
ABA number	121000358	121000358
Account number	12334-03557	12350-02104

Request that your bank make payments using the Cash Concentration or Disbursement Plus (CCD+) format. In the field for "Payment Detail/ID Name," insert your billing unit number by following this example:

- If your billing unit number is **000001234-0001,** then enter **CID 001234 EU 0001 ABC Company.**

Note: Insert the letters **CID** and include only enough leading zeros to create a six-digit number. Follow this with a space, the letters **EU,** another space, and enough leading zeros to create a four-digit number. Then enter your company name as it appears on your Kaiser Permanente contract.

To set up a wire transfer:

Provide the bank with this information:

Wire transfers	Accounts in Northern California	Accounts in Southern California
Bank name	Bank of America	Bank of America
Bank address	100 West 33rd St. New York, NY 10001	100 West 33rd St. New York, NY 10001
Account name	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
ABA number	0260-0959-3	0260-0959-3
Account number	12334-03557	12350-02104

In the field for "Payment Detail," insert your billing unit number by following this example:

- If your billing unit number is **000001234-0001,** then enter **CID 001234 EU 0001 ABC Company.**

Note: Insert the letters **CID** and include only enough leading zeros to create a six-digit number. Follow this with a space, the letters **EU,** another space, and enough leading zeros to create a four-digit number. Then enter your company name as it appears on your Kaiser Permanente contract.

In the field for "Comments," insert "Kaiser California Health Plan Membership Dues."

For answers to questions about ACH payments or wire transfers, please contact:
Customer Solutions Center at 800-731-4661, option 4.

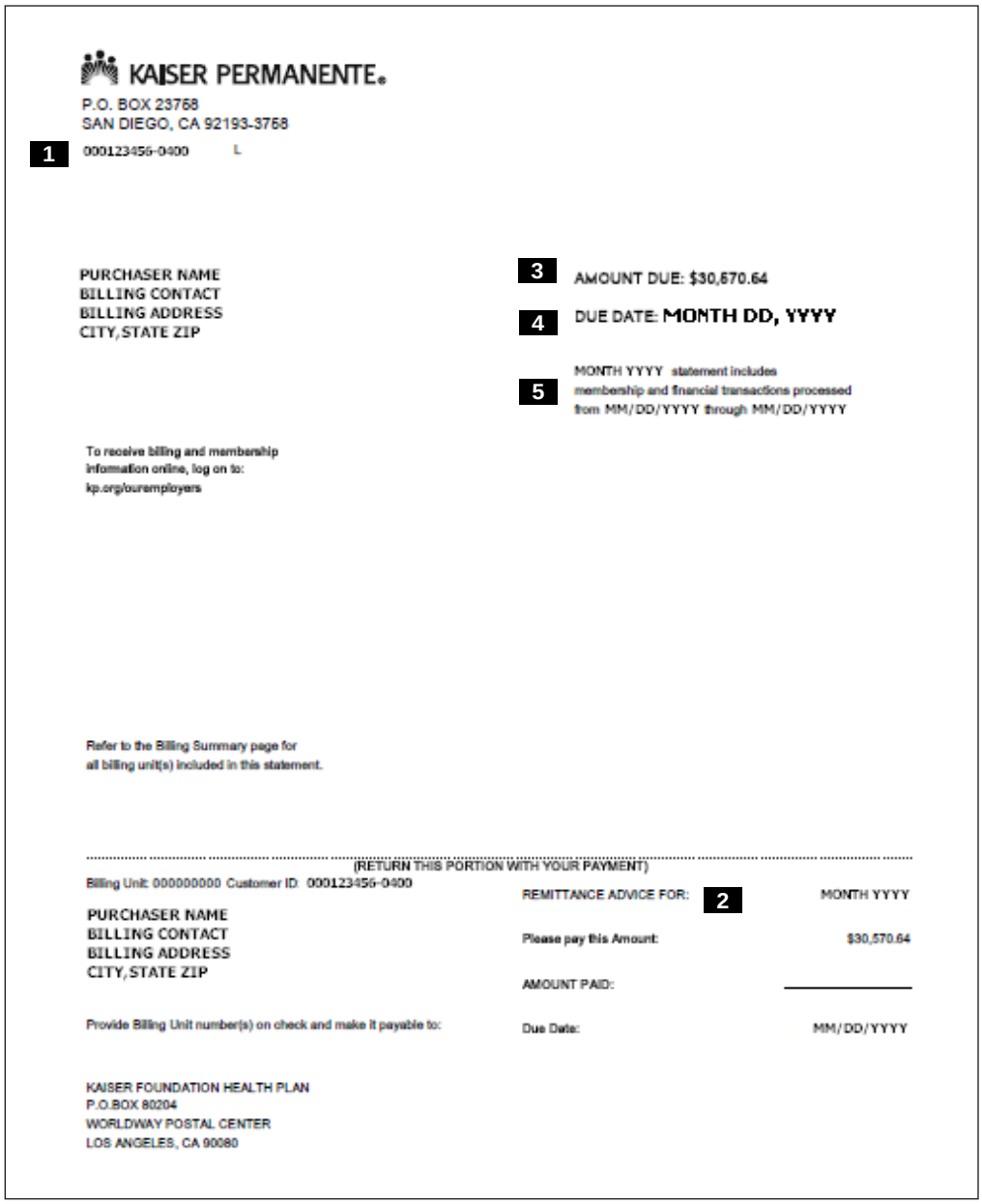
HOW TO READ THE MONTHLY MEMBERSHIP BILLING STATEMENT

Membership billing statement and remittance advice

The monthly membership billing statement includes a remittance advice to submit with payment, as well as a number of sections that provide detailed membership and payment information about your Kaiser Permanente coverage. The membership billing statement displays the coverage month being billed, membership and payment transactions processed for an activity period, and the total amount due.

For easy reference, use the membership and payment addresses located on the first page of the membership billing statement. The bottom portion of the statement page is a remittance advice that is to be returned with your payment. This remittance advice assists us in processing your payment correctly and quickly.

Membership Billing Statement



KAISER PERMANENTE®
P.O. BOX 23758
SAN DIEGO, CA 92193-3758
1 000123456-0400 L

PURCHASER NAME
BILLING CONTACT
BILLING ADDRESS
CITY, STATE ZIP

3 AMOUNT DUE: $30,670.64

4 DUE DATE: MONTH DD, YYYY

5 MONTH YYYY statement includes membership and financial transactions processed from MM/DD/YYYY through MM/DD/YYYY

To receive billing and membership information online, log on to:
kp.org/touremployers

Refer to the Billing Summary page for all billing unit(s) included in this statement.

(RETURN THIS PORTION WITH YOUR PAYMENT)

Billing Unit: 000000000 Customer ID: 000123456-0400

PURCHASER NAME
BILLING CONTACT
BILLING ADDRESS
CITY, STATE ZIP

REMITTANCE ADVICE FOR: 2 MONTH YYYY

Please pay this Amount: $30,570.64

AMOUNT PAID: _____

Provide Billing Unit number(s) on check and make it payable to:

Due Date: MM/DD/YYYY

KAISER FOUNDATION HEALTH PLAN
P.O.BOX 80204
WORLDWAY POSTAL CENTER
LOS ANGELES, CA 90080

Field name and description

1 **Primary Billing Unit—**The billing unit of your coverage. This statement reflects transactions for all members covered under this billing unit and secondary (child) billing units.

2 **Coverage Month—**The coverage month for this billing statement.

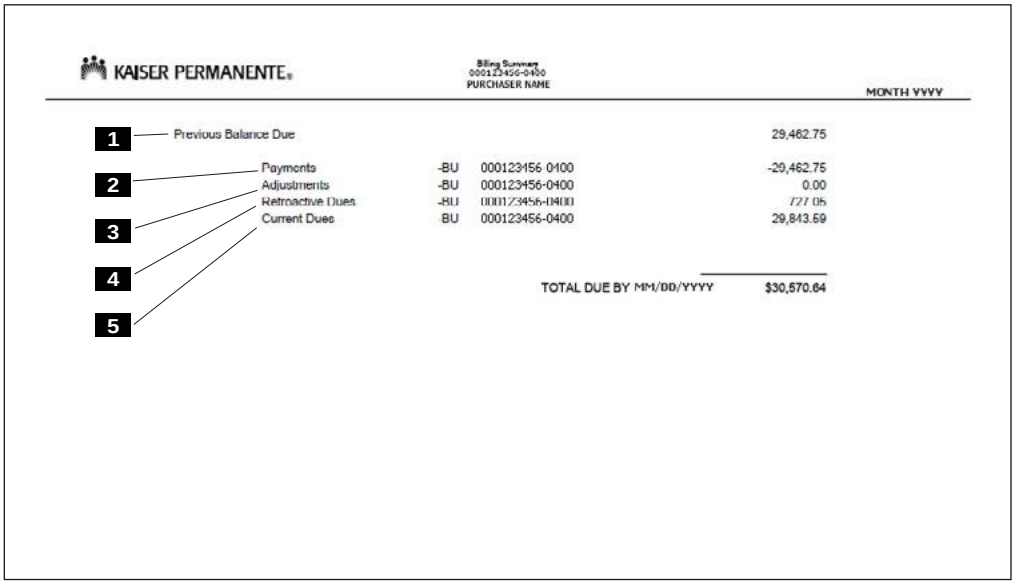
3 **Amount Due—**The total payment due to Kaiser Permanente. This reflects the total amount owed for all open coverage month balances minus all credit balances and unallocated payments.

4 **Payment Due Date—**Date by which your payment must be processed. Remember to allow for mailing and processing time.

5 **Activity Period—**Subscriber transactions (membership and billing) processed within this time frame (activity period) will reflect on this bill.

Billing Summary

The Billing Summary section summarizes payment and allocation activities for all billing unit(s).



Field name and description

1 **Previous Balance Due—**The total charges from the previous month.

2 **Payments—**The amount remitted and allocated for each billing unit. For allocation details, see Billing Detail/Payments Detail section of the bill.

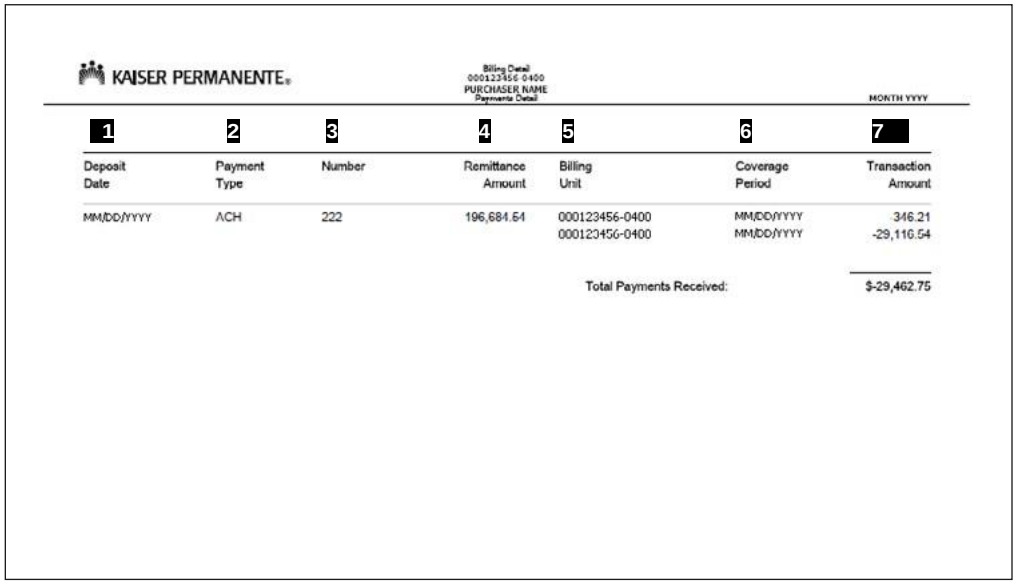
3 **Adjustments—**The charge(s)/credit(s) due for account adjustment transaction(s) for each billing unit. For details, see Billing Detail/Adjustments section of the bill.

4 **Retroactive Dues—**The charge(s)/credit(s) due for retroactive transactions for each billing unit. For details, see Billing Detail/Membership Activity Detail section of the bill.

5 **Current Dues—**The entire amount of current dues for the coverage period for each billing unit. For details, see Billing Detail/Current Dues section of the bill.

Billing Detail/Payments Detail

The Billing Detail/Payments Detail section reflects payments allocated by billing unit and coverage period.



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Billing Detail
000123456 0400
PURCHASER NAME
Payments Detail

MONTH YYYY

1 Deposit Date	2 Payment Type	3 Number	4 Remittance Amount	5 Billing Unit	6 Coverage Period	7 Transaction Amount
MM/DD/YYYY	ACH	222	196,684.64	000123456-0400	MM/DD/YYYY	346.21
				000123456-0400	MM/DD/YYYY	-29,116.54
				Total Payments Received:		$-29,462.75

Field name and description

1 **Deposit Date—**The date your payment was processed by our bank.

2 **Payment Type—**The method by which your remittance was sent.

3 **Number—**The check or reference number of your remittance.

4 **Remittance Amount—**The amount of your payment.

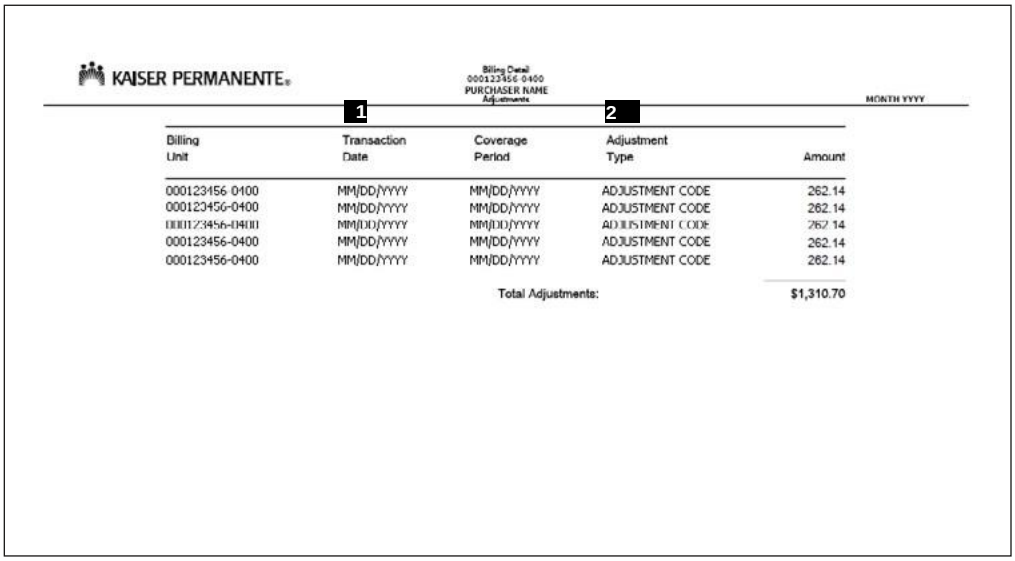
5 **Billing Unit—**The billing unit(s) where your payment was applied.

6 **Coverage Period—**The month for which your payment was applied.

7 **Transaction Amount—**The amount that was applied to the corresponding billing unit.

Billing Detail/Adjustments

The Billing Detail/Adjustments section lists the billing unit(s) with adjustments.



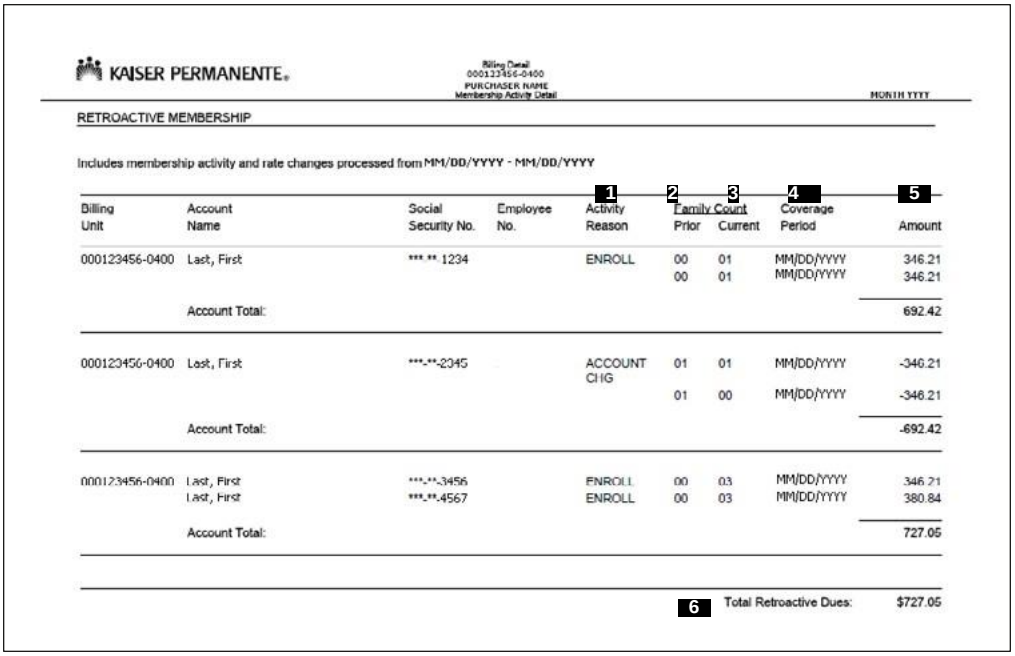
Field name and description

1 **Transaction Date—**The date when the adjustment was processed.

2 **Adjustment Type—**The type of adjustment that resulted from the change of activity or status.

Billing Detail/Membership Activity Detail

The Billing Detail/Membership Activity Detail section lists all transactions processed during the current activity period. These transactions include new enrollments, family account changes, and terminations at the member level. Transactions that can't be processed are listed as rejected. Future enrollments and transactions that require further documentation are listed as pending.



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Billing Detail
000123456-0400
PURCHASER NAME
Membership Activity Detail

MONTH YYYY

RETROACTIVE MEMBERSHIP

Includes membership activity and rate changes processed from MM/DD/YYYY - MM/DD/YYYY

Billing Unit	Account Name	Social Security No.	Employee No.	1 Activity Reason	2 Family Count Prior	3 Family Count Current	4 Coverage Period	5 Amount
000123456-0400	Last, First	***-**-1234		ENROLL	00	01	MM/DD/YYYY	346.21
					00	01	MM/DD/YYYY	346.21
	Account Total:							692.42
000123456-0400	Last, First	***-**-2345		ACCOUNT CHG	01	01	MM/DD/YYYY	-346.21
					01	00	MM/DD/YYYY	-346.21
	Account Total:							-692.42
000123456-0400	Last, First	***-**-3456		ENROLL	00	03	MM/DD/YYYY	346.21
	Last, First	***-**-4567		ENROLL	00	03	MM/DD/YYYY	380.84
	Account Total:							727.05

6 Total Retroactive Dues: $727.05

Field name and description

1 **Activity Reason—**The reason for the retroactive transaction (e.g., enroll, reinstate, terminate).

2 **Prior Family Count—**The number of eligible members in a family prior to the corresponding retroactive transaction being processed.

3 **Current Family Count—**The number of eligible members after the retroactive transaction was processed.

4 **Coverage Period—**The month of coverage for which the retroactive transaction applies.

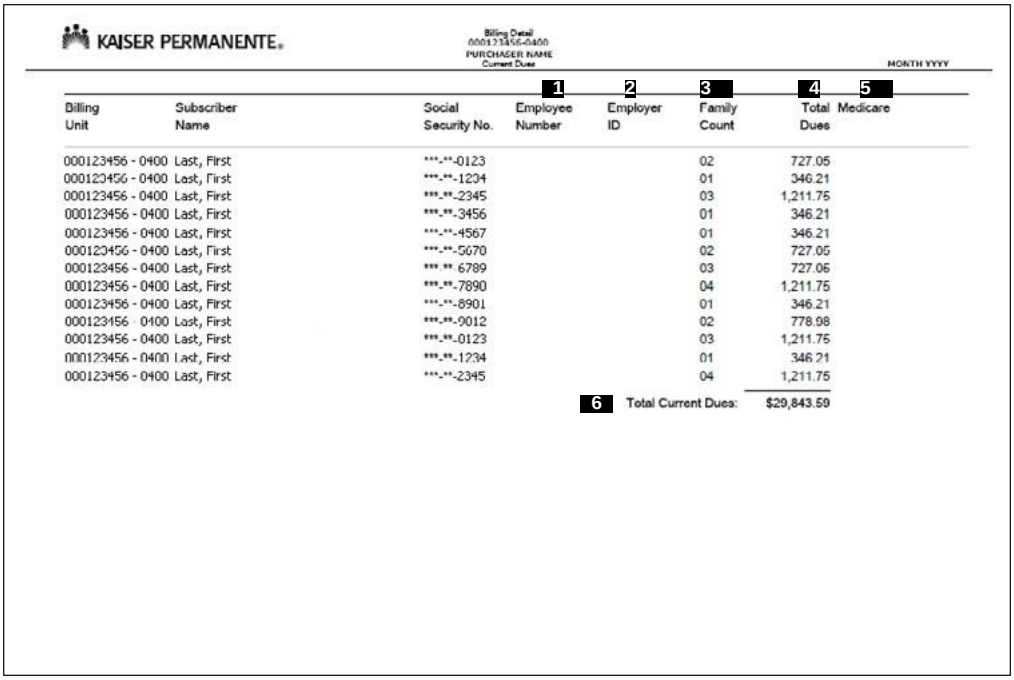
5 **Amount—**The charge(s)/credit(s) resulting from the retroactive transaction.

6 **Total Retroactive Dues—**The entire amount of retroactive billing for the activity period.

Billing Detail/Current Dues

The Billing Detail/Current Dues section reports dues by family account (per subscriber). The members shown on the detail are eligible for coverage during the coverage month.

If you have requested a detail at the member level (subscriber and their dependents individually listed), this section is replaced by the Billing Detail/Membership Current Dues section (see below).



KAISER PERMANENTE®

Billing Detail
0001234560400
PURCHASER NAME
Current Dues

MONTH YYYY

Billing Unit	Subscriber Name	Social Security No.	1 Employee Number	2 Employer ID	3 Family Count	4 Total Dues	5 Medicare
000123456 - 0400	Last, First	***-**-0123			02	727.05	
000123456 - 0400	Last, First	***-**-1234			01	346.21	
000123456 - 0400	Last, First	***-**-2345			03	1,211.75	
000123456 - 0400	Last, First	***-**-3456			01	346.21	
000123456 - 0400	Last, First	***-**-4567			01	346.21	
000123456 - 0400	Last, First	***-**-5670			02	727.05	
000123456 - 0400	Last, First	***-** 6789			03	727.05	
000123456 - 0400	Last, First	***-**-7890			04	1,211.75	
000123456 - 0400	Last, First	***-**-8901			01	346.21	
000123456 - 0400	Last, First	***-**-9012			02	778.98	
000123456 - 0400	Last, First	***-**-0123			03	1,211.75	
000123456 - 0400	Last, First	***-**-1234			01	346.21	
000123456 - 0400	Last, First	***-**-2345			04	1,211.75	

6 Total Current Dues: $29,843.59

Field name and description

1 Employee Number—Your group can utilize the Employee Number field that appears on the monthly billing statement. This can be any 9-digit, alphanumeric code that can be used to separate populations.

2 Employer ID—The number of the location to which the member is assigned as provided by the customer (blank if not maintained for your billing unit).

3 Family Count—The number of eligible member in a family.

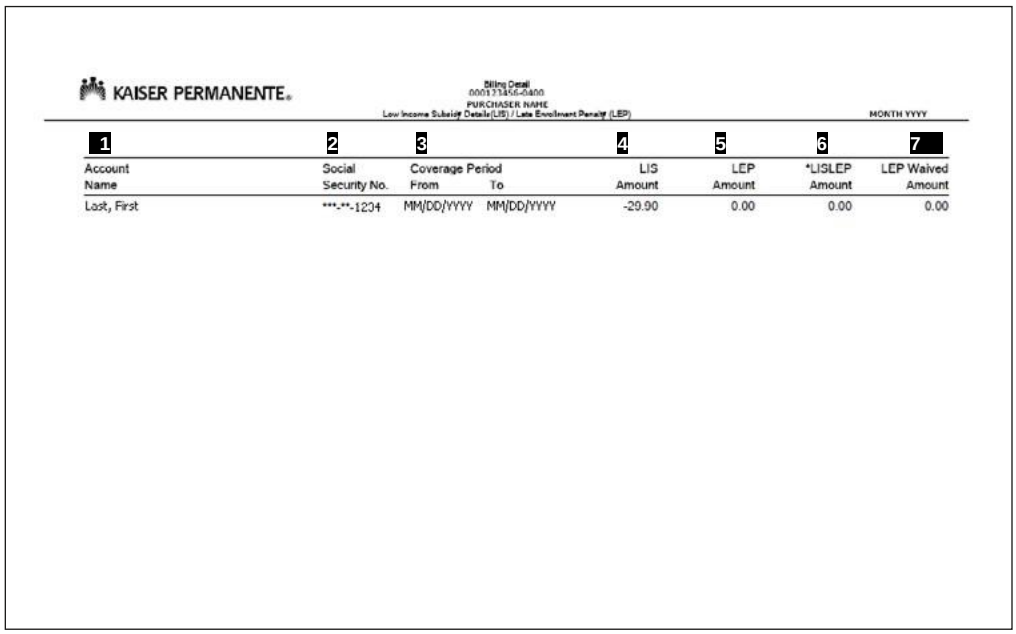
4 Total Dues—The entire amount billed and due for each subscriber.

5 Medicare—The Medicare status for the family account. A "Y" indicates that at least one member in the family has Medicare. An "N" indicates that the subscriber is at least 65 an eligible for Medicare, but has not assigned their Medicare Part B to Kaiser Permanente.

6 Total Current Dues—The total amount due for all subscriber for the coverage period.

Low-Income Subsidy Details/Late Enrollment Penalty

The Billing Detail/Low-Income Subsidy Details (LIS)/Late Enrollment Penalty (LEP) section reflects Medicare members' LIS/LEP status and any charges associated with their account.



KAISER PERMANENTE®

Billing Detail
0001234567-0400
PURCHASER NAME
Low Income Subsidy Details (LIS) / Late Enrollment Penalty (LEP) MONTH YYYY

1	2	3		4	5	6	7
Account Name	Social Security No.	Coverage Period From	To	LIS Amount	LEP Amount	*LISLEP Amount	LEP Waived Amount
Last, First	***-**-1234	MM/DD/YYYY	MM/DD/YYYY	-29.90	0.00	0.00	0.00

Field name and description

1 **Account Name—**The name of the Medicare member.

2 **Social Security No.—**The Social Security number of the member.

3 **Coverage Period—**The month for which the charges apply.

4 **LIS Amount—**The amount credited from Low Income Subsidies.

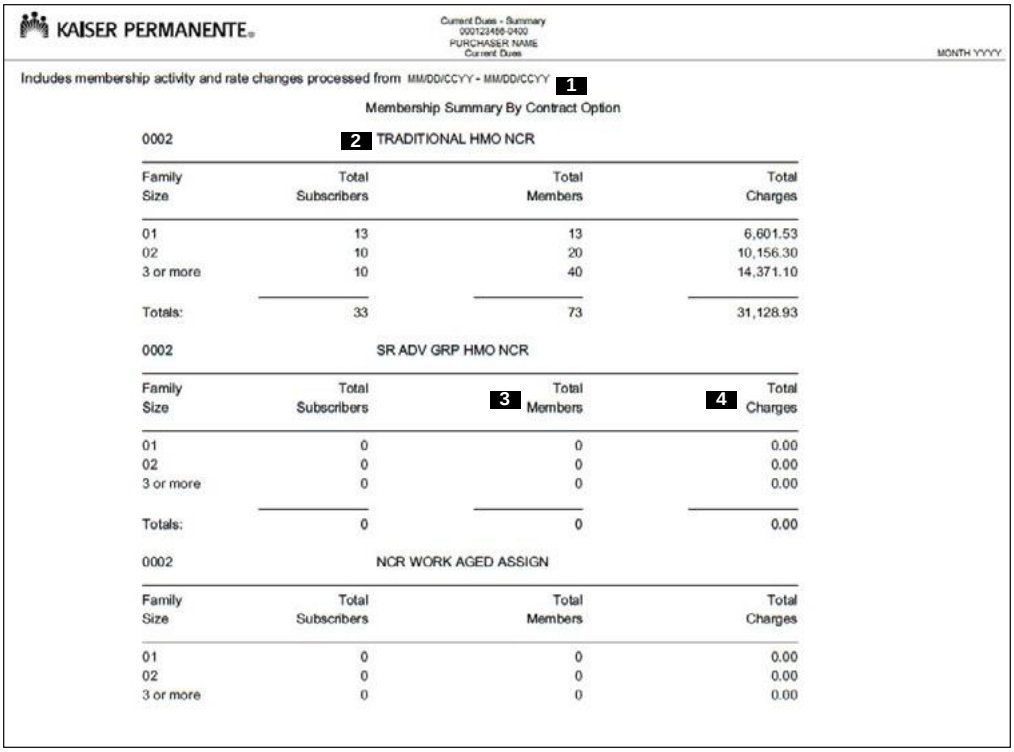
5 **LEP Amount—**The amount billed as a Late Enrollment Penalty.

6 **LISLEP Amount—**The amount credited to Late Enrollment Penalties from Low Income Subsidies.

7 **LEP WAIVED Amount—**The amount waived from the Late Enrollment Penalty.

Current Dues—Summary

The Current Dues—Summary section lists the total charges and number of members for each contract option that applies to your group.



KAISER PERMANENTE

Current Dues - Summary
000123456-0400
PURCHASER NAME
Current Dues

MONTH YYYY

Includes membership activity and rate changes processed from MM/DD/CCYY - MM/DD/CCYY 1

Membership Summary By Contract Option

0002 2 TRADITIONAL HMO NCR

Family Size	Total Subscribers	Total Members	Total Charges
01	13	13	6,601.53
02	10	20	10,156.30
3 or more	10	40	14,371.10
Totals:	33	73	31,128.93

0002 SR ADV GRP HMO NCR

Family Size	Total Subscribers	3 Total Members	4 Total Charges
01	0	0	0.00
02	0	0	0.00
3 or more	0	0	0.00
Totals:	0	0	0.00

0002 NCR WORK AGED ASSIGN

Family Size	Total Subscribers	Total Members	Total Charges
01	0	0	0.00
02	0	0	0.00
3 or more	0	0	0.00

Field name and description

1 **Membership Activity—**Transactions processed within this time frame to reflect on this bill.

2 **Contract Option—**The contract options that are available to you and the current dues for each option.

3 **Total Members—**The total number of members for the contract option for the coverage period.

4 **Total Charges—**The total dues for each contract option for the coverage period.

SELF-REPORTING

Self-reporting is the process of generating a membership roster and payment on a monthly basis for premiums that are sent to Kaiser Permanente. The roster and payment are compared to Kaiser Permanente's membership and accounting system. All differences are reported back as discrepancies and must be addressed with the following month's payment.

Note: Groups that utilize the self-reporting method will not receive an invoice from Kaiser Permanente. For further detail about self-reporting, reach out to your account manager.

Discrepancies from self-reporting customers

When we process your monthly premium report and reconcile your account, we may find you've made overpayments or underpayments that result in discrepancies. We'll send you a discrepancy report. The discrepancy report also itemizes the net discrepancy amount. Please review the reconciliation, research each discrepancy, and respond to any discrepancies listed with your next premium payment. This report is also available electronically from the California Service Center.

Understanding discrepancy reports

Kaiser Permanente has two discrepancy reports. These reports are generated and sent once the monthly reconciliation has been processed. This is where you will view your discrepancies and any credits or debits remaining on your account.

- Close Month Reports are generated and sent monthly, once the reconciliation has been completed. This report contains all discrepancies that were identified and/or created during the current month that was processed. This includes the member's information as well as the discrepancy type and associated dues.
- Cumulative Reports are generated and sent quarterly, although they can be produced upon request. This report contains all discrepancies that are open for your account, regardless of the coverage month in which they were created. This includes the member's information as well as the discrepancy type and associated dues.

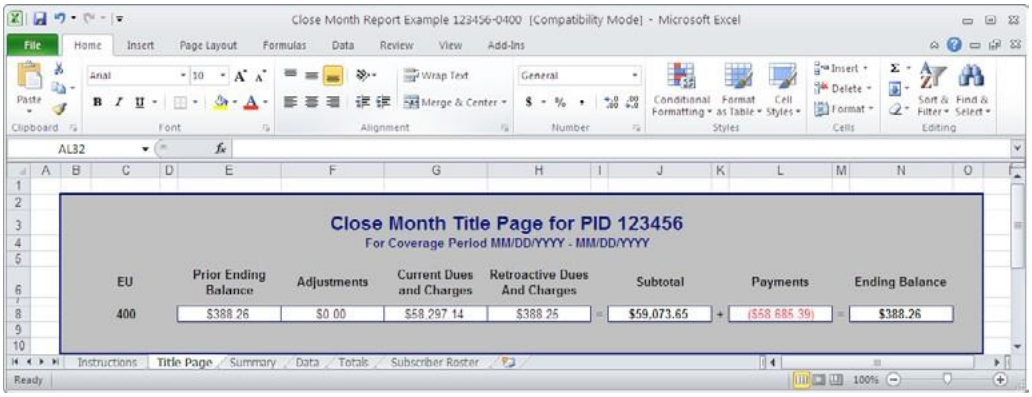
Resolving discrepancies

Discrepancies can be resolved by paying the amount due, correcting the membership, correcting the reported discrepancy (for example, by effective/termination date), or submitting the missing documentation.

HELPFUL HINT

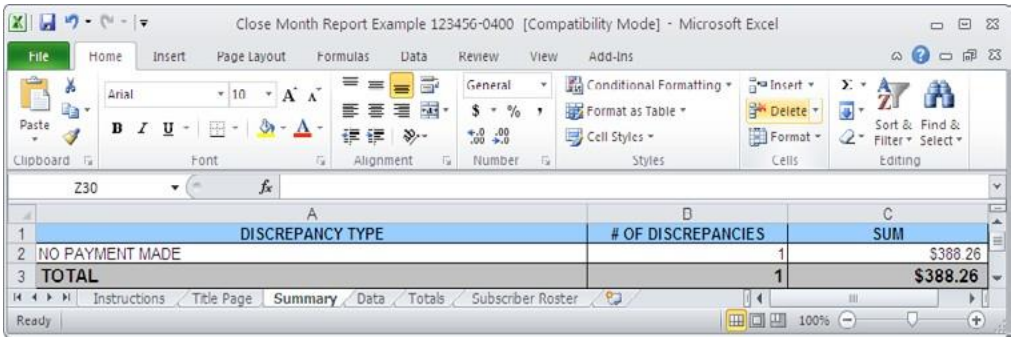
Being consistent and timely in reporting membership and making premium payments will minimize discrepancies.

Close Month Discrepancy Report



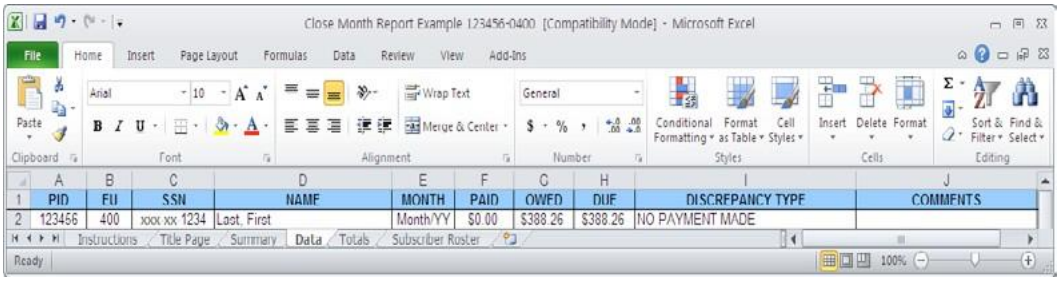
- **Close Month Report Title page—**Use this title page to verify the ending balance for your account, once the reconciliation has been processed. This page also includes adjustments, and current and retroactive dues.

Close Month Discrepancy Report



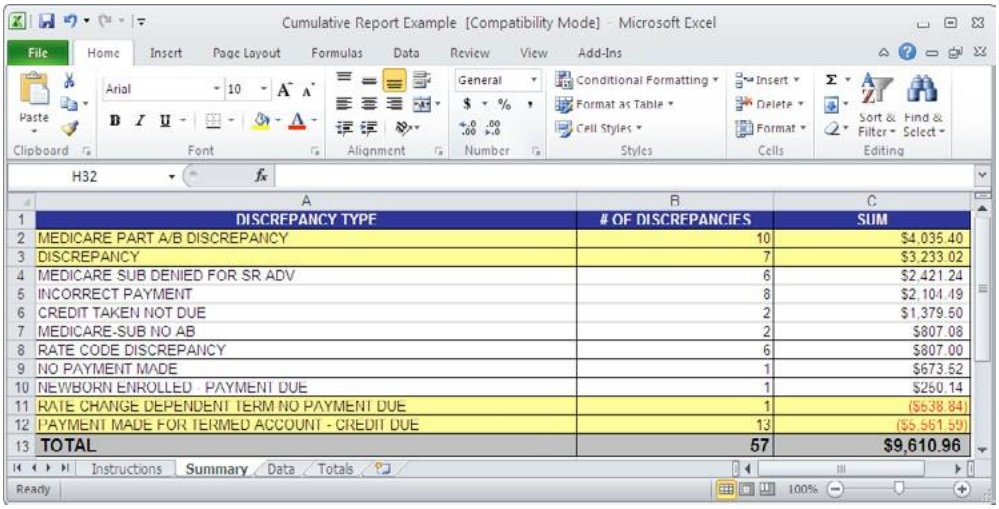
- **Close Month Report Summary page—**Use this summary page to identify the total amount of open discrepancies by discrepancy type, for the current reconciled month.

Close Month Discrepancy Report



- **Close Month Report Data page—**Use this page to identify and review all discrepancies by member for the current reconciled month. This page includes the coverage month, discrepancy details, and all associated dues.

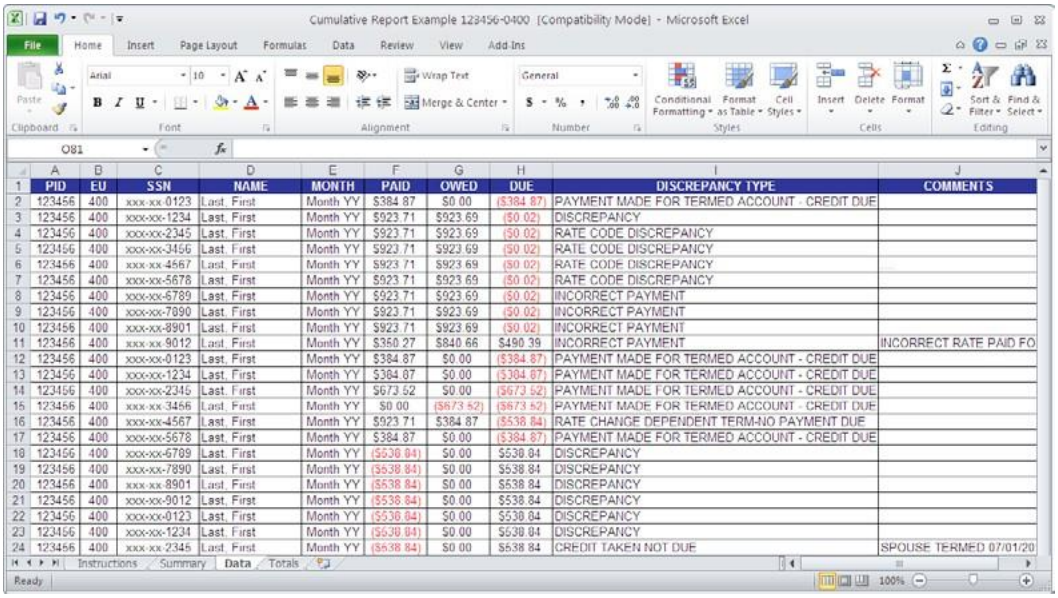
Cumulative Discrepancy Report



	A	B	C
1	DISCREPANCY TYPE	# OF DISCREPANCIES	SUM
2	MEDICARE PART A/B DISCREPANCY	10	$4,035.40
3	DISCREPANCY	7	$3,233.02
4	MEDICARE SUB DENIED FOR SR ADV	6	$2,421.24
5	INCORRECT PAYMENT	8	$2,104.49
6	CREDIT TAKEN NOT DUE	2	$1,379.50
7	MEDICARE-SUB NO AB	2	$807.08
8	RATE CODE DISCREPANCY	6	$807.00
9	NO PAYMENT MADE	1	$673.52
10	NEWBORN ENROLLED - PAYMENT DUE	1	$250.14
11	RATE CHANGE DEPENDENT TERM NO PAYMENT DUE	1	($638.84)
12	PAYMENT MADE FOR TERMED ACCOUNT - CREDIT DUE	13	($5,561.59)
13	TOTAL	57	$9,610.96

- **Cumulative Report Summary page—**Use this summary page to identify the total amount of open discrepancies by discrepancy type, for all coverage periods.

Cumulative Discrepancy Report



Cumulative Report Example 123456-0400 [Compatibility Mode] - Microsoft Excel

	A	B	C	D	E	F	G	H	I	J
1	PID	EU	SSN	NAME	MONTH	PAID	OWED	DUE	DISCREPANCY TYPE	COMMENTS
2	123456	400	xxx-xx-0123	Last, First	Month YY	$384.87	$0.00	($384.87)	PAYMENT MADE FOR TERMED ACCOUNT - CREDIT DUE	
3	123456	400	xxx-xx-1234	Last, First	Month YY	$923.71	$923.69	($0.02)	DISCREPANCY	
4	123456	400	xxx-xx-2345	Last, First	Month YY	$923.71	$923.69	($0.02)	RATE CODE DISCREPANCY	
5	123456	400	xxx-xx-3456	Last, First	Month YY	$923.71	$923.69	($0.02)	RATE CODE DISCREPANCY	
6	123456	400	xxx-xx-4567	Last, First	Month YY	$923.71	$923.69	($0.02)	RATE CODE DISCREPANCY	
7	123456	400	xxx-xx-5678	Last, First	Month YY	$923.71	$923.69	($0.02)	RATE CODE DISCREPANCY	
8	123456	400	xxx-xx-6789	Last, First	Month YY	$923.71	$923.69	($0.02)	INCORRECT PAYMENT	
9	123456	400	xxx-xx-7890	Last, First	Month YY	$923.71	$923.69	($0.02)	INCORRECT PAYMENT	
10	123456	400	xxx-xx-8901	Last, First	Month YY	$923.71	$923.69	($0.02)	INCORRECT PAYMENT	
11	123456	400	xxx-xx-9012	Last, First	Month YY	$350.27	$840.66	$490.39	INCORRECT PAYMENT	INCORRECT RATE PAID FO
12	123456	400	xxx-xx-0123	Last, First	Month YY	$384.87	$0.00	($384.87)	PAYMENT MADE FOR TERMED ACCOUNT - CREDIT DUE	
13	123456	400	xxx-xx-1234	Last, First	Month YY	$384.87	$0.00	($384.87)	PAYMENT MADE FOR TERMED ACCOUNT - CREDIT DUE	
14	123456	400	xxx-xx-2345	Last, First	Month YY	$673.52	$0.00	($673.52)	PAYMENT MADE FOR TERMED ACCOUNT - CREDIT DUE	
15	123456	400	xxx-xx-3456	Last, First	Month YY	$0.00	($673.52)	($673.52)	PAYMENT MADE FOR TERMED ACCOUNT - CREDIT DUE	
16	123456	400	xxx-xx-4567	Last, First	Month YY	$923.71	$384.87	($538.84)	RATE CHANGE DEPENDENT TERM-NO PAYMENT DUE	
17	123456	400	xxx-xx-5678	Last, First	Month YY	$384.87	$0.00	($384.87)	PAYMENT MADE FOR TERMED ACCOUNT - CREDIT DUE	
18	123456	400	xxx-xx-6789	Last, First	Month YY	($538.84)	$0.00	$538.84	DISCREPANCY	
19	123456	400	xxx-xx-7890	Last, First	Month YY	($538.84)	$0.00	$538.84	DISCREPANCY	
20	123456	400	xxx-xx-8901	Last, First	Month YY	($538.84)	$0.00	$538.84	DISCREPANCY	
21	123456	400	xxx-xx-9012	Last, First	Month YY	($538.84)	$0.00	$538.84	DISCREPANCY	
22	123456	400	xxx-xx-0123	Last, First	Month YY	($538.84)	$0.00	$538.84	DISCREPANCY	
23	123456	400	xxx-xx-1234	Last, First	Month YY	($538.84)	$0.00	$538.84	DISCREPANCY	
24	123456	400	xxx-xx-2345	Last, First	Month YY	($538.84)	$0.00	$538.84	CREDIT TAKEN NOT DUE	SPOUSE TERMED 07/01/20

- **Cumulative Report Data page—**Use this page to identify and review all open discrepancies by member for all coverage months. This page includes the coverage month, discrepancy details and all associated dues.

INTRODUCTION: MEDICARE OVERVIEW

What is Medicare? Medicare is a federally funded national health insurance program. It pays for medical care for:

- The nation's elderly (those 65 and older).
- Certain disabled persons.
- Current Kaiser Permanente members with end-stage renal disease (ESRD).

Medicare Parts A and B are part of the original Medicare plan (also called the "fee-for-service" plan) managed by the federal government. It has been in effect since 1965 and is available nationwide. Medicare Parts A and B provide a broad spectrum of basic benefits. The coverage includes:

- Part A—Hospital insurance (inpatient).
- Part B—Supplemental medical insurance (outpatient).

Medicare Part A

- Designed to provide basic protection against the cost of inpatient hospital care and other institution-provided inpatient or home health care.
- No cost to eligible beneficiaries.
- Financed largely through hospital insurance taxes imposed by the Internal Revenue Code and normally assessed and collected as part of the Social Security tax, collected under the Federal Insurance Contributions Act (FICA).

Medicare Part B

- A voluntary supplementary program covering the cost of physicians' services and a number of other outpatient services not covered under the Part A program.
- Requires a monthly charge for eligible participants.
- Financed largely through these monthly premiums and contributions from the federal government.

Medicare Part D

On January 1, 2006, the Medicare Modernization Act (MMA) expanded Medicare to cover outpatient prescription drug costs, called Medicare Part D. Part D affects individual plans and options for customers differently, but all plans offering Part D must conform to certain minimums and standards called the Standard Medicare Part D Plan in order to be compensated by the federal government for providing outpatient prescription drug coverage.

MEDICARE ELIGIBILITY

Most individuals become entitled to hospital insurance benefits (Medicare Part A) when they reach age 65, have worked long enough in covered employment (or are the spouse of a worker), and file an application with the Social Security Administration (SSA). Part A eligibility is also available to individuals under 65 if they are entitled to either Social Security disability benefits, railroad retirement disability benefits, or ESRD benefits.

Individuals 65 or older who are not entitled to Part A may enroll in Part A through their Social Security Administration office by paying a monthly premium. Medicare Part B is a voluntary program for eligible individuals. Enrollment in Part B is open only to those persons who are:

- Entitled to Part A benefits.
- Age 65 or older, residents of the United States, and:
  - Citizens of the United States
  - Aliens lawfully admitted to the United States for permanent residence who have resided in the United States continuously during the five years immediately preceding the month in which application for enrollment is made.

Medicare Part D is open only to those persons who are:

- Entitled to Part A and enrolled in Part B.
- Entitled to Part A and/or Part B.

HOW TO ENROLL IN MEDICARE

Medicare Part A

Most people not already receiving Social Security benefits become eligible for Medicare by reaching age 65. They must file an application with the SSA, unless they're already receiving Social Security benefits, to become entitled to Medicare. Individuals not currently receiving Social Security checks should apply for Social Security/Medicare three months before their 65th birthday.

Medicare Part B

Through the local SSA offices, Medicare offers eligible beneficiaries (those entitled to Part A) three opportunities to enroll in Medicare Part B, the supplementary insurance portion of Medicare.

1. Initial enrollment period—For those individuals entitled to Part A upon reaching age 65. Initial enrollment is based on the date the individual first meets the eligibility requirements for enrollment. This period begins on the first day of the third month before the month in which the individual first meets eligibility requirements, and it ends seven months later.

HOW TO ENROLL *(continued)*

2. General enrollment period—For those individuals who fail to enroll during the initial enrollment period or who terminated their Part B enrollments but want to re-enroll. This period is from January through March of each year, with coverage effective July 1 of the same year.

3. Special enrollment period—If, after turning 65, employees have employer group health plan coverage, they will have a special enrollment period. They may enroll in Part B or Part A at any time they are covered under the group health plan or may wait and enroll during the eight-month period beginning with the month they or their spouse stops working or when they are no longer covered under the employer plan, whichever comes first.

If individuals don't enroll during this special enrollment period, they must wait until the next general enrollment period. Premiums for Part B are generally higher if individuals wait to enroll during a general enrollment period.

Medicare administration

- Administered through the federal Centers for Medicare & Medicaid Services (CMS) and local SSA offices.
- CMS contracts with health care providers, such as Kaiser Permanente, to manage health care services for Medicare-eligible members.
- SSA offices accept applications for Medicare and assist beneficiaries with entitlement, enrollment, claims, and premium problems.

KAISER PERMANENTE'S MEDICARE PROGRAM

Kaiser Permanente Senior Advantage

- Kaiser Permanente's Medicare plan is called Kaiser Permanente Senior Advantage.
- For current and prospective Kaiser Permanente members who are entitled to Medicare Part A and enrolled in Medicare Part B, or enrolled in Part B only.
- Coverage provided for urgent care when the Medicare beneficiary is outside our Health Plan service area. (This is in addition to other CMS-mandated benefits.)

Unlike Medicare, Kaiser Permanente also provides coverage to its enrolled Medicare beneficiaries for emergency care anywhere in the world. Unless otherwise referred or authorized by Kaiser Permanente, members must receive all of their non-emergency health care services from Kaiser Permanente. Neither Kaiser Permanente nor Medicare will pay for routine out-of-plan services not authorized by us.

KAISER PERMANENTE'S MEDICARE PROGRAM *(continued)*

Kaiser Permanente Senior Advantage with Part D

Employers or trust funds can enroll Medicare-eligible retirees in a Kaiser Permanente Part D plan and then supplement the standard Medicare Part D benefit design, in order to produce a more comprehensive benefits package. With this option, Kaiser Permanente, not the customer, is reimbursed by the federal government for providing outpatient prescription drug benefits.

Kaiser Permanente Senior Advantage with the Retiree Drug Subsidy

Employers can elect to receive the Retiree Drug Subsidy (a 28 percent subsidy) from the government if they provide prescription drug coverage that meets or exceeds the standard Part D plan.

Value to the member/employee

The integration of Medicare and Kaiser Permanente Health Plan benefits broadens your employees' health care coverage. Kaiser Permanente Senior Advantage's integrated benefits help your eligible Medicare beneficiaries meet their health care needs.

Kaiser Permanente Senior Advantage benefits include:

- No worrying about finding physicians who accept Medicare assignment.
- No Medicare-disallowed charges for covered services.

Kaiser Permanente Senior Advantage includes the following health benefits that aren't covered by Medicare:

- Routine physical examinations.
- Routine immunizations.
- Hearing examinations, eye examinations, lenses, and frames.
- Health education.
- Emergency coverage outside the United States.
- Dental care, if employer subscribes.

To assist you in answering questions about administering Kaiser Permanente health benefits, you can now access the *Administrative Handbook for Large Accounts* online at account.kp.org.

KAISER PERMANENTE SENIOR ADVANTAGE ELIGIBILITY

Who is eligible?

Individuals must be entitled to Medicare Part A and enrolled in Medicare Part B, or enrolled in Part B only, to be eligible to enroll in Kaiser Permanente Senior Advantage.

- Current Kaiser Permanente members or prospective members who live in a Kaiser Permanente Senior Advantage service area.
- Current Kaiser Permanente members who are eligible for Medicare as a result of ESRD, but who were members of the Health Plan at the time of certification of ESRD.

Kaiser Permanente Member Age-In Program

At Kaiser Permanente, we've established an automated system that identifies and solicits members approaching age 65 to enroll in Kaiser Permanente Senior Advantage.

Our enhanced communication plan includes easy-to-understand mailings that can help your Medicare eligibles make important decisions about their Medicare choices. Members begin receiving communications on their 64th birthday and again at strategic points throughout the year following their 64th birthday.

After the enrollment period, they'll receive reminder emails or calls until they enroll or let us know they're delaying enrollment. Late retirees will receive communications twice a year to remind them about advantages of our Medicare plans and how to enroll or request additional information once they do retire.

ENROLLMENT: HOW TO JOIN KAISER PERMANENTE SENIOR ADVANTAGE

Notification to employer of prospective Kaiser Permanente Senior Advantage members

Members must enroll in our Kaiser Permanente Senior Advantage program for you to receive the lower monthly premium. Those members who enroll and those who don't enroll (but are eligible) are reported to you on the Monthly Medicare Activity Report. If you're not receiving this report, you may request it through your Kaiser Permanente Account Manager.

Special Medicare Part D situations

There are two Medicare Part D situations that could cause a Medicare member's regular monthly premium to change: Low Income Subsidy and Late Enrollment Penalty.

Low Income Subsidy—Financial assistance is offered to qualified beneficiaries who have limited income and resources. Your employees can apply for the LIS through either Social Security or the Medi-Cal program office. Social Security also mails LIS applications on a monthly basis to encourage potentially eligible members to apply for extra help.

ENROLLMENT *(continued)*

In the monthly statements or closed month reports received, you'll see an LIS premium refund amount for qualified members. You should use this refund to offset the amount that the member contributes toward his or her Medicare health plan premium, up to the amount of the subsidy. In cases where the subsidy is greater than the beneficiary's total premium contribution, the beneficiary should be fully refunded his or her contribution while the remainder of the subsidy may be retained by the employer.

Late Enrollment Penalty—A CMS-imposed fee may be added to a member's monthly premium for individuals who did not enroll in a Medicare drug plan during their initial enrollment period and who did not have creditable coverage for a continuous period of 63 days or more after their initial enrollment period.

In the monthly statements or closed month reports received, you'll see an LEP premium fee amount for qualified members. Although the employer must pay Kaiser Permanente for any LEP fees, it is the employer's decision whether to recoup paid fees from its members.

Special enrollment situations

The following situations are handled differently from the standard Kaiser Permanente Senior Advantage enrollment process:

Medicare Secondary Payer (MSP)—These are members and their covered spouses who:

- Are enrolled through an employer affected by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) regulations.
- Continue to work after becoming eligible for Medicare.

Enrollment in Kaiser Permanente Senior Advantage is optional for these members. If they decide to join Kaiser Permanente Senior Advantage, they must enroll in Medicare Part B with Social Security and pay Part B premiums. Currently, the employer pays the under-age-65 rate for these members. Employers can inform but cannot encourage these members to join Kaiser Permanente Senior Advantage because the decision must be made solely by the members.

Medicare Enrollments—Members who submit a Medicare election form directly to Kaiser Permanente will be enrolled into your group Kaiser Permanente Senior Advantage plan as of the first of the month following the date we receive the form. If the member indicates a start date on the form that is later than the receipt date, the enrollment will be effective as of the later date as allowed by CMS regulations.

For those groups that collect completed Kaiser Permanente Senior Advantage election forms and send them to Kaiser Permanente on behalf of their members, the same process for determining the effective enrollment date applies. We ask that you stamp these forms indicating the date you received the form from the member to avoid a delay in the

effective date. Because of Medicare regulations, if an election form received from an employer group is date stamped, the effective date of the enrollment will be the first of the month after the employer group date stamp, or the member's effective date on the group, whichever is later. This is true even if Kaiser Permanente received the form up to two months after the proposed election date. For example, if a member signs the form on December 15 and the group receives it from the member on December 20 and stamps the date at that time, the effective enrollment date will be January 1—even if we don't get the form from the group until February 15. However, if the form is not date stamped by the group, the effective date will be the first of the month after Kaiser Permanente receives the form. In the example above, the effective date for the member would be March 1. We understand that your internal processing may cause some delays in getting that form to us in time to meet the anticipated start date. In those cases, date stamping the form will allow us to make the enrollment effective the first of the month after you have received the form from the member.

Of course, exceptions to all of the above may apply if the member is not yet entitled to Medicare.

Out-of-area enrollment—Individuals who reside outside the Kaiser Permanente service area may not enroll in Kaiser Permanente Senior Advantage. Members may contact the Member Service Contact Center to determine if they reside in a Kaiser Permanente service area.

Open enrollment for retirees

If you have an annual retiree open enrollment period for all of your health care plans, request Kaiser Permanente Senior Advantage enrollment packets and election forms for your Medicare-eligible employees from your Kaiser Permanente account manager.

Changing health plans

Enrollment in a Medicare fee-for-service plan—Employers should notify us if a Kaiser Permanente Senior Advantage member chooses a Medicare fee-for-service plan. With that information and appropriate documentation, we can release the member's Medicare benefits in a timely manner to ensure no loss of coverage.

Disenrollment from Kaiser Permanente Senior Advantage—Enrollment in another Medicare Advantage plan automatically terminates the member's enrollment in Kaiser Permanente Senior Advantage. If the member wishes to disenroll from Kaiser Permanente Senior Advantage but is not enrolling in another Medicare Advantage plan, the member must sign and complete a disenrollment form or request disenrollment in writing. Disenrollment from Kaiser Permanente Senior Advantage could result in a higher rate for the employer unless you terminate those members' Health Plan coverage in a timely manner.

ENROLLMENT *(continued)*

Note: Request Kaiser Permanente Senior Advantage materials one to two months before open enrollment to allow sufficient time for delivery.

DISENROLLMENT FROM KAISER PERMANENTE SENIOR ADVANTAGE

INVOLUNTARY DISENROLLMENT FROM KAISER PERMANENTE SENIOR ADVANTAGE

The following circumstances could result in a member's termination from Kaiser Permanente Senior Advantage or Health Plan enrollment, or could result in an increase in the employer's premium. In each circumstance, the employer decides. Refer to Policy Decisions the Employer Must Make on page 3-13 and 3-14.

Member loses Medicare (Part A or Part B) entitlement

Employers pay the lowest monthly premium for members who are enrolled in Kaiser Permanente Senior Advantage and who have both Medicare Part A and Part B. Upon notification by CMS of a change in Medicare status (that is, loss of Medicare Part A or Part B), we notify the member. Employers are notified via the Monthly Medicare Activity Report (MMAR).

Loss of Medicare Part A

If a member loses Part A after joining Kaiser Permanente Senior Advantage, he or she will be required to enroll in Part B only with Kaiser Permanente Senior Advantage, and the employer's payment obligation may be higher.

Loss of Medicare Part B

Kaiser Permanente Senior Advantage members must continue their enrollment in Medicare Part B to maintain their Kaiser Permanente Senior Advantage eligibility or they will be disenrolled.

Loss of Medicare Part D

If the member disenrolled from Kaiser Permanente Senior Advantage, and your group offered Part D, then the member will lose the Part D coverage.

Kaiser Permanente initiates disenrollment for Kaiser Permanente Senior Advantage members who move out of a Kaiser Permanente service area. If the employer knows that a member is moving out of our service area and is making arrangements for other insurance options (not a Medicare Advantage plan), the employer should obtain a written disenrollment request from the member.

CMS will notify us if a member joins another Medicare Advantage plan or reports an out-of-service-area address to the SSA. All other disenrollments must be requested in writing by the Kaiser Permanente Senior Advantage member or with a disenrollment form signed by the Kaiser Permanente Senior Advantage member.

Disenrollment requests become effective the fi of the month following the date the request is received by Kaiser Permanente. Kaiser Permanente Senior Advantage members must continue to seek medical services from Kaiser Permanente until their disenrollment is effective. If they receive services from a provider other than Kaiser Permanente, they are liable for all costs except costs for emergency and out-of-area urgent care services.

Kaiser Permanente Senior Advantage enrollment rejection

CMS may reject, or not permit, enrollment in Kaiser Permanente Senior Advantage for the following reasons:

- Member is not entitled to Medicare Part A and is not enrolled in Part B.
- Member has ESRD.

Process followed with enrollment rejections

- Members are notified of the rejection.
- A copy of their Medicare card is requested so we can verify entitlements with CMS.
- Upon receipt of the correct information, we resubmit the names to CMS for Kaiser Permanente Senior Advantage enrollment at the end of the next enrollment cutoff.
- We allow a three-month "correction" period before action on membership is taken.
- If the member is eligible for Kaiser Permanente Senior Advantage and is still not enrolled after two attempts to enroll, Kaiser Permanente works directly with the CMS regional office to enroll the member.

SSA/CMS errors

Occasionally, the SSA or CMS erroneously reports that a beneficiary is deceased or has lost entitlement to either Medicare Part A or Part B. When these situations arise, Kaiser Permanente informs members directly. Members must correct the errors directly with the SSA, and they must do so within 45 days of notification by Kaiser Permanente.

Important facts regarding terminated members

- Employers must notify Kaiser Permanente of the reason for a Medicare member's termination.
- When an employee leaves Kaiser Permanente to go to another health plan, with appropriate documentation we'll immediately disenroll them from Kaiser Permanente Senior Advantage to allow them to enroll with the other health plan. (See Disenrollment from Kaiser Permanente Senior Advantage on page 3–8.)
- If we don't receive a written disenrollment request from the member, we can't release the Medicare enrollment. In this case, members will be automatically transferred to our Kaiser Permanente Senior Advantage conversion plan for individuals.

INVOLUNTARY DISENROLLMENT FROM KAISER PERMANENTE SENIOR ADVANTAGE *(continued)*

- If the employer does not offer a Part D benefit, members will be disenrolled from Kaiser Permanente Senior Advantage.
- These members must continue to pay their Part B (and Parts A and D, if applicable) premiums.
- Members should be aware that their individual Kaiser Permanente Senior Advantage plan benefits may be different from their employer group Kaiser Permanente Senior Advantage benefits.

Advance notification for terminating Medicare members

CMS requires that group members in a Kaiser Permanente Senior Advantage plan receive written notice from their employer's plan at least 21 days prior to termination.

- Because of this advance notice requirement, KPSA plan group members may not be terminated retroactively.
- So that we can comply with the requirements set forth by CMS, employer groups must notify Kaiser Permanente at least 30 days before the effective termination date for members in a Kaiser Permanente Senior Advantage plan.
- If notification is not received within the 30-day time frame, the employer will be charged the member premium for an additional month.

Monthly Medicare Activity Report

Changes to your employees' Medicare status are reported on the Monthly Medicare Activity Report (MMAR). This report is not cumulative, meaning that each status change is reported to you only once. All status changes are reported, regardless of whether the change results in a rate change.

The MMAR is produced on the designated date an employer requests. If there are no changes to the report in any given month, you'll receive only the summary. The report lists all changes for Medicare members that have been verified by CMS, as well as new member information reported by the member.

Rate development—If you have any questions about how your Health Plan rates are developed and computed, please discuss them with your account management team.

Audit frequency of your customer unit—We recommend that you conduct a periodic audit of all members enrolled through your customer unit. An audit can identify enrollment or payment problems early, and usually allows for easier resolution of those problems. An audit also ensures that an employer is providing coverage and paying only for legitimate and eligible members. Please call the California Service Center to establish a schedule for audits of your customer unit.

Direct billing for group Medicare members

Normally, group Medicare members are included on the monthly statements you receive or the premium reports you send. In turn, you may have to bill the retiree for the premiums you paid Kaiser Permanente. With direct billing for group Medicare plans, you can regain valuable time and resources that positively impact your bottom line. There's no additional charge for this service.

Along with eliminating the costs of printing and mailing invoices, you may also see substantial savings on other resources. You won't have to worry about sending out bills, collecting delinquent payments, or other administrative functions. We'll take care of it for you.

Fast Facts about direct billing:

- Direct billing is only available for your retirees 65 and older in a Medicare group plan—not those in a commercial plan.
- You and your retirees will continue to enjoy the advantages of your current Kaiser Permanente group Medicare health plan with no change in plan benefits.
- Your retiree will receive a letter from us introducing them to direct billing and explaining how it works.
- Direct billing participants will receive a monthly bill, usually no later than the 20th of each month.
- Your retirees will be able to pay by check, electronic funds transfer, or credit or debit card if they call the Member Service Contact Center. Members can also pay online using a credit or debit card.
- As the plan sponsor, you'll continue to perform other administrative responsibilities, such as producing the summary plan, transferring employees from their active enrollment unit to the new direct-billing enrollment unit, informing your retirees of rate and benefit changes, and changing their employment status to retired.
- If you are interested in direct billing for your group Medicare members, please contact your Account Manager.

Important facts regarding terminated members

The administration of a comprehensive health care coverage plan that integrates Kaiser Permanente Health Plan benefits and Medicare benefits requires coordination among a number of different parties:

- Kaiser Permanente
- Employer
- Member/employee
- Federal agencies (CMS and the SSA)

ROLES AND RESPONSIBILITIES *(continued)*

Kaiser Permanente

- Provides basic Medicare and Kaiser Permanente Senior Advantage program information to members who are reaching age 65 and/or who are becoming newly eligible for Medicare benefits.
- Processes Kaiser Permanente Senior Advantage enrollment requests and disenrollment forms.
- Submits documentation to CMS for processing.
- Monitors Medicare and Kaiser Permanente Senior Advantage enrollment status.
- Notifies members and employers of any changes in enrollment status.
- Answers questions from employers and members about Kaiser Permanente Senior Advantage benefits, rates, and enrollment status.
- Acts as a liaison to CMS.
- Assists employers in periodic audits of members age 65 and older and other Medicare-eligible employees and dependents.
- Determines rate impact of members' Medicare status, as reported by CMS, and reports to employers.
- Administers policies mutually agreed upon between employers and Kaiser Permanente.

Employer

- Reports the following promptly to the Health Plan:
  - New and terminated subscribers and dependents.
  - Employment status changes for subscribers age 65 and older (for example, working-aged to retired status).
- Enforces TEFRA/DEFRA/OBRA/COBRA guidelines as applicable.
- Pays monthly dues as requested by the Health Plan.
- Monitors eligibility of subscribers and dependents for the Health Plan benefits (e.g., changes due to deceased members, divorces, returns to work).
- Performs periodic audits of members with the Health Plan, age 65, and older and other Medicare-eligible employees and dependents.
- Administers policies related to Medicare eligibility and Kaiser Permanente Senior Advantage enrollment, which have been agreed upon between the employer and the Health Plan.

Member/employee

- Enrolls in Kaiser Permanente Senior Advantage when eligible.
- Provides the Health Plan with all information necessary to enroll in Kaiser Permanente Senior Advantage.
- Continues to pay Medicare Part B (and Part A if applicable) premiums in order to maintain enrollment in Kaiser Permanente Senior Advantage.
- Reports to the employer or to the Health Plan: change of address, including moves outside of the service area, or a dependent's Medicare entitlement changes.
- Complies with employer's enrollment guidelines.

Federal agencies

- Centers for Medicare & Medicaid Services (CMS):
  - Approves and confirms Kaiser Permanente Senior Advantage enrollment.
  - Notifies Health Plan of changes in Medicare entitlement and Kaiser Permanente Senior Advantage enrollment involving Health Plan members.
  - Monitors, audits, approves administrative processes and written communications to members involving Kaiser Permanente Senior Advantage.
- Social Security Administration (SSA):
  - Acts as customer service liaison to CMS for matters involving Medicare entitlement.
  - Provides written information to Medicare beneficiaries concerning Medicare benefits and entitlement.

For each of the following situations, the employer must make decisions that will affect the member's Kaiser Permanente Senior Advantage enrollment and/or the rate the employer is charged for the member. These decisions are generally made when your Health Plan contract is signed.

POLICY DECISIONS THE EMPLOYER MUST MAKE

POLICY DECISIONS THE EMPLOYER MUST MAKE *(continued)*

Non-enrollment in Kaiser Permanente Senior Advantage or loss of Part A or Part B entitlement

If a member does any of the following:

- Fails or declines to enroll in Kaiser Permanente Senior Advantage.
- Loses Medicare Part A or Part B entitlement once he or she is enrolled in Kaiser Permanente Senior Advantage.
- Enrolls in another Medicare Advantage plan while a member of Kaiser Permanente Senior Advantage.

Employer decision

- Employer will pay increased premium or pass the cost to employee.
- Employer will not pay increased premium and will report those employees who don't have Part A or Part B as Kaiser Permanente coverage terminations.
- Employer will not pay increased premium, which allows Kaiser Permanente to terminate coverage for employees automatically. (Not an option for electronically reporting employers.)

INTRODUCTION

The information in this section is not intended as legal advice. If this information differs from applicable law, the law prevails. Should you have any questions specific to your group or need more detailed information, Kaiser Permanente suggests that you consult your legal counsel or the U.S. Department of Labor.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires certain employers to provide continuation of group health coverage to employees and their covered dependents when their group health coverage with that employer would otherwise terminate.

Under the Employee Retirement Income Security Act (ERISA), the employer's Employee Welfare Benefit Plan has the fiduciary responsibility for all aspects of COBRA administration. The Plan Administrator (as defined by ERISA) is the employer or a third party administrator appointed by the employer. Kaiser Permanente performs only clerical COBRA functions for employer groups. It has not and does not accept fiduciary responsibility as a COBRA administrator for any employer group. Kaiser Permanente is, however, a Plan Fiduciary (as defined by ERISA solely) for determining the scope and extent of health care coverage for those ERISA Plan beneficiaries enrolled through the group as our members, including those participating through COBRA. If your employees call Kaiser Permanente for federal COBRA enrollment information, they will be told to contact their employer for assistance.

COBRA

Monthly billing of your COBRA members

You (or your designee) will bill and collect the premiums for all your COBRA members and will pay Kaiser Permanente for all your COBRA members as a group, just as you do for your active employees. You would not send Kaiser Permanente individual payments for each COBRA member.

Note: A designee refers to a third party administrator that you contract with to perform some or all of your group's administration functions.

How to enroll COBRA members

When an employee or dependent chooses to elect Kaiser Permanente COBRA coverage, he or she must complete a Kaiser Permanente COBRA enrollment form, which must be submitted directly to the group. You will then submit the enrollment form and report any terminations in the way you usually report membership changes. We will not accept any COBRA enrollment forms directly from your employees. Kaiser Permanente will accept enrollment only for the minimum time frames as specified in COBRA. Members who intend to elect and pay for COBRA coverage may use Kaiser Permanente services during

the interim between their termination from health coverage and their enrollment into COBRA. You should make them aware of the following:

- It is recommended, but not mandatory, that members retain a copy of their COBRA enrollment form to use as a temporary ID.
- If the individual uses services, but does not elect to pay for Kaiser Permanente COBRA coverage, Kaiser Permanente will bill the individual as a nonmember for all services received.

Employee notification

It is always the employer's responsibility to notify employees about federal COBRA, including any information regarding new rates or benefit changes. Members who call Kaiser Permanente for COBRA enrollment information will be referred back to their employers.

Termination of employer contract

A COBRA enrollment unit is attached to the active contract. If the Group Agreement for the active account is terminated, the COBRA enrollment unit is terminated as well. Terminated COBRA participants may be offered the opportunity to convert to a Kaiser Permanente individual membership account.

Open enrollment changes

If you have COBRA participants who elect to change from a different carrier to Kaiser Permanente during an open enrollment period, you must notify Kaiser Permanente of the original COBRA start date(s) of the participant(s).

CAL-COBRA

The California Continuation Benefits Replacement Act (Cal-COBRA) allows continued access to group health coverage by:

- Former employees and their dependents of employers of two to 19 eligible employees (including church groups).
- Enrollees who have exhausted continuation coverage under federal COBRA, if the enrollee is entitled to less than 36 months of federal COBRA.

Cal-COBRA coverage is available for up to 36 months to:

- Subscribers and dependents who have exhausted continuation coverage under federal COBRA if the subscriber and dependents are entitled to less than 36 months of federal COBRA.

- Subscribers and dependents when the subscriber loses employment with the customer through which he or she enrolled for reasons other than gross misconduct.
- Subscribers and dependents when the subscriber's hours are reduced and he or she no longer qualifies for group coverage.
- A dependent who loses group coverage due to divorce or legal separation.
- A dependent who loses group coverage due to death of the subscriber.
- A dependent child who marries or reaches the age limit for group membership or who experiences a change in custody.
- A dependent when a subscriber becomes entitled to Medicare.

Billing and payment

Kaiser Permanente handles billing and collection of payments for Cal-COBRA. Dues are billed by and paid to the Health Plan. Kaiser Permanente bills and collects directly from the subscriber.

Please request an updated report from us whenever you need to know which former employee(s) are enrolled through your Cal-COBRA account.

Kaiser Permanente sends a notification of Cal-COBRA to all group members terminating group health care coverage. The notice is included with other options that may be available. If your employees have any questions about Cal-COBRA, have them contact a member service representative at **1-800-464-4000.**

Member notification for those enrolled in federal COBRA

Kaiser Permanente will notify members who have exhausted their COBRA coverage (if they're entitled to fewer than 36 months of federal COBRA) of their opportunity to enroll in Cal-COBRA and extend the term of their continuation coverage to 36 months. The notice is included with other options that may be available. If your employees have any questions about COBRA, have them contact a member service representative at **1-800-464-4000.**

ARBITRATION LANGUAGE[1] AND FORM APPROVAL

Q: Is collecting binding arbitration signatures new?

A: No. Requiring members to sign a notice about arbitration isn't a new requirement, or one that's unique to Kaiser Permanente. California Health and Safety Code Section requires that any health plan using binding arbitration to settle disputes must disclose information about the agreement to the subscriber/enrollee at the point of enrollment. The language must be prominently displayed, and the signature of the subscriber/enrollee must be directly below the disclosure. The arbitration notice embedded in the group contract, while also required by the statute, doesn't fulfill the requirement of notice to the subscriber/enrollee at the point of enrollment.

Q: What does binding arbitration mean?

A: Binding arbitration settles member disputes in a less formal proceeding than a civil lawsuit in state or federal court. With arbitration, an impartial decision-maker, called an arbitrator, is selected by the parties themselves or through an independent organization. After the parties engage in pretrial discovery of documents and other information, they then participate in an arbitration trial at which both sides can present evidence and testimony. The arbitrator's decision is usually final. The majority of health plans use binding arbitration, and we've used it to resolve member disputes since 1971.

Q: Have I seen the binding arbitration notice before?

A: Yes. Kaiser Permanente's binding arbitration notice is in your group agreement above the group's signature line, and we have a process for collecting signed arbitration notices from subscribers/enrollees who enroll manually. If you use Kaiser Permanente paper enrollment forms, you're already compliant with the state's enrollment notice requirement, since those forms include our arbitration notice.

Q: Who is involved in the agreement to arbitrate?

A: The agreement to arbitrate is part of Kaiser Permanente's enrollment process. Arbitration is between Kaiser Permanente and the subscriber/ enrollee who chooses Kaiser Permanente coverage for himself or herself and eligible dependents. Employers, brokers, and third-party administrators (TPAs) are not parties to this arbitration agreement. The group agreement by itself isn't sufficient to meet legal requirements concerning the arbitration notice.

Q: If I'm processing enrollments through Customer Account Services (CAS), can I agree to Kaiser Permanente's arbitration notice for the subscriber/enrollee?

A: No. Administrators processing enrollments through CAS can only select "agree" if they already have the subscriber/enrollee's signed arbitration notice on a Kaiser Permanente paper enrollment form, approved universal enrollment form, or through an enrollment website that displays the arbitration notice and requires the subscriber/ enrollee's signature to comply with the state requirements.

Q: When must a subscriber/enrollee agree to binding arbitration?

A: If a health plan uses binding arbitration, regulations require that the subscriber/enrollee receive written notice at the point of enrollment. Your employees must provide a signature or electronic signature immediately beneath the notice to confirm that they have read and agree to arbitration.

Q: If a subscriber/enrollee doesn't agree to arbitration, will Kaiser Permanente decline enrollment?

A: Yes. If a subscriber/enrollee does not agree to arbitration notice, they (and their dependents) will not be able to enroll in a Kaiser Permanente plan.

Q: If a subscriber/enrollee enrolls without signing the arbitration notice (for example, the language isn't on the document or online enrollment site), can Kaiser Permanente go back to the subscriber/enrollee to get their signed agreement to arbitrate?

A: No. If a subscriber/enrollee enrolls in a Kaiser Permanente plan without signing our arbitration notice, we can't go back to the subscriber to collect their agreement after the fact.

Q: What does Kaiser Permanente's arbitration agreement say?

A: Kaiser Permanente's arbitration agreement is in the group agreement and members' *Evidence of Coverage* that's part of your group contract. It's listed as "Binding Arbitration" in the "Dispute Resolution" section in the table of contents of the group agreement.

Q: Is Kaiser Permanente changing its process for collecting signatures under arbitration notices on paper enrollment forms/administrators' universal forms?

A: No. Paper processes are not impacted.

Q: What are the advantages of CAMS?

A: **CAMS** Ensures the arbitration language is automatically updated without any action from your team.

- Collects the enrollee's agreement and archives it to Kaiser Permanente's secured web portal.
- One time initial integration set up.
- One time initial screen shot approval.

Q: Will CAMS impact EDI files and/or reporting?

A: No. Reporting processes are not impacted.

Q: How will the new online arbitration management system integrate with third-party online enrollment sites?

A: Our designers will work with administrators (brokers, employer groups, TPAs) to collect system requirements to ensure compatibility.

Q: Where should the CAMS functionality be added within my enrollment site?

A: The CAMS functionality may be added at any point within your enrollment site as long as it appears before the subscriber/enrollee completes the enrollment process.

Q: Will my employees have to sign on or log in to CAMS to sign the arbitration notice?

A: There's no sign-on or login.

Q: Instead of using CAMS, can I host Kaiser Permanente's arbitration notice within my enrollment website?

A: Yes. The following requirements will need to be met:

- Maintain the arbitration language (including certifying, then recertifying the language annually).
- Capture and archive, indefinitely, the arbitration notice as signed by the subscriber/ enrollee.
- Prevent any subscriber/enrollee who declines arbitration from being enrolled in a Kaiser Permanente plan.

Q: How can I get more information on CAMS?

A: Contact your Kaiser Permanente representative or visit account.kp.org.

ONLINE ACCOUNT ADMINISTRATION (ONLINE ACCOUNT SERVICES)

Q: What are online account services?

A: Our online account services are developed specifically to help employers manage their Kaiser Permanente health plan accounts. These services allow you to:

- Add or terminate employee and dependent memberships.
- Change employee and dependent demographic information.
- View a list of subscribers and their covered dependents.
- View your balance due.
- View your monthly bill.
- View transaction history.
- Pay your bill.

Q: Are these services free?

A: Yes.

Q: How can I sign up for online account services?

A: You can register for access via this link:
https://account.kp.org/broker-employer/resources/employer/floating/requestuserid/

- An email will be sent to the primary user with an access code and instructions on how to register for an employer account.
- Once registered, click on "Enter your access code" on the home page.
- On the "Enter access code" page, the primary group administrator enters the access code to gain full access to the group functions.
- Once the primary group administrator is set up, that person can authorize additional user.

Q: Will I still receive a paper bill?

A: Yes, you'll continue to receive a paper bill. However, you can opt out to not receive a paper bill if you prefer.

Q: Do I have to use the Internet for everything?

A: No. We're offering you the use of the Internet as an added convenient way to work with us, because we think it'll make the administration of your Kaiser

Permanente health plan easier. You can think of these online services as a "health plan ATM" that provides you with faster service. You still can call the California Service Center at any time for one-on-one customer service.

Q: Can I enter new enrollments online?

A: Yes. You can enter new enrollments, provided that the customer handles the enrollments as prescribed by the online enrollment guidelines. This means that the customer retains all completed and signed enrollment forms or proof of enrollment if a telephonic interactive voice response (IVR), electronic/website or online enrollment process is used.

The customer retains such enrollment documentation for future reference if there is a question as to who enrolled when or whether the customer's enrollment provided notice about Kaiser Permanente's use of binding arbitration at the point of enrollment as prescribed by California law. Terminations may also be handled online. For changes outside the allowed time frame, please contact the California Service Center.

Q: Will this online service handle Medicare and COBRA enrollments for my employees?

A: COBRA enrollments can be processed using online account services. For Medicare enrollments, please contact your Kaiser Permanente account manager for more information on Kaiser Permanente Senior Advantage enrollments.

Q: How do I know which former employees and dependents are currently enrolled in COBRA or Cal-COBRA?

A: If you have a COBRA billing unit where you are responsible for billing the member, you may see your COBRA members.

- Go under the billing unit on your account and select the "Subscriber List" function under "Member Functions." If you have COBRA or Cal-COBRA in which Kaiser Permanente is responsible for the billing, this is not an option because these accounts don't have a group billing unit and are billed directly to the member by Kaiser Permanente.
- The list of members enrolled in COBRA or Cal-COBRA where Kaiser Permanente is responsible for the billing, is sent out monthly to the billing contact.

Q: Will my employees have access to the service?

A: No. This service is designed for you to manage your group's health plan accounts online. However, your employees who have selected Kaiser Permanente as their health plan can use our member website at kp.org.

Q: Can I have an additional user ID for another person in my office?

A: Absolutely. Kaiser Permanente will provide you with one user ID. Your user ID gives you "administrator" privileges. It allows you to create additional user IDs for those you wish to access the site and vary their privileges according to their responsibilities. (You'll find this function under the "Account Access" drop-down menu within the website.)

Q: Is this a secure website?

A: Yes. Our website is protected by data firewalls and several leading antivirus software products, making external access extremely difficult. Our data centers are high-security facilities monitored around the clock to prevent unauthorized access. Data center visitors must have an appointment, a valid ID, and an internal escort. We also have internal and external auditors and compliance officers routinely evaluate the performance of technical controls in our data processing centers.

Account

A subscriber and all his or her eligible enrolled family dependents.

Account Administration Representative (AAR)

CSC Account Administration Representative (AAR) manages the administration, billing, and integrity of accurate membership information to ensure that members receive uninterrupted medical services while simultaneously safeguarding Kaiser Permanente's financial book of business.

Account Manager

The Kaiser Permanente marketing and sales representative responsible for the ongoing management of existing customer/employer accounts.

Account number

The subscriber's medical record number. The subscriber "governs" the account, and certain transactions applied to the subscriber account record will cause a change to all the member records within the account, such as a membership address change. A change to the subscriber's personal information (e.g., a birth date change) will only change the subscriber's record and not any member records within the account.

Activity period

The actual date range used to select actions such as membership activity, payment allocations, and adjustments for use in dues-owed calculations. For billed customers and Kaiser Permanente for Individuals and Families accounts, this is the activity that will be reported on the bill. For non-billed customers, this is the period used to reconcile the remittance to membership activity.

Activity reason

Certain transactions, such as member enrollments or contract terminations, have a field to record the trigger, or reason, the activity took place.

Allocate

A payment, once received, is applied to a billing unit and then applied or allocated to a coverage period.

Apply

A received payment is applied to a billing unit.

Balance

The amount due or payable on an account. It can be either a credit or debit amount.

Billing cycle

The frequency with which membership dues are billed for health plan coverage.

Billing date or billing schedule

The actual cutoff day for transactions used in dues-owed calculations for billed employers. It can be any calendar day of the month. The billing frequency and billing date together define the activity period for a specific billing unit.

Billing unit or enrollment unit

The customer-defined segment and associated facts (billing address, contact person, etc.) into which a health plan employer's or individual's transactions, such as membership activity, payment allocations, and adjustments, are grouped for billing purposes and reconciliation.

Broker

A third party, either an individual or company, that sells Kaiser Permanente health plans. The broker usually receives a commission associated with the sale and sometimes serves as the contact for an employer.

Cal-COBRA (California Continuation Benefits Replacement Act)

California continuation coverage that allows continued access to California group health coverage for:

1. Qualified former employees, and their dependents, of employers of two to 19 eligible employees (including church groups).
2. Enrollees who have exhausted continuation coverage under federal COBRA; if the enrollee is entitled to less than 36 months of federal COBRA (the total months of continuation coverage under both federal COBRA and Cal-COBRA will not exceed 36 months).

California Service Center (CSC)

A statewide processing center that handles group and individual member administrative functions, such as: contracts processing, membership processing, billing and delinquency, reconciliation/account review, remittance processing, and membership and revenue reporting.

Centers for Medicare & Medicaid Services (CMS)

The federal agency that administers the Medicare program.

Certificate of Insurance (COI)/Schedule of Coverage (SOC)

The documents given to an insured employee stating the benefits and provisions of a group plan that directly affect the insured's rights and those of his or her beneficiaries. It is not a contract, but serves as evidence of insurance and is subject to legal requirements.

Client Services Unit (CSU)

The Client Services Unit is a team of customer service experts who can answer your questions about large groups—those with 101 or more members.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985; an act requiring certain employers to provide continuation of group health coverage to employees and certain covered dependents when their group health coverage with that employer would otherwise terminate.

Contract

1. An agreement that defines the non–period-specific provisions under which Kaiser Foundation Health Plan, Inc. (KFHP) commits to provide administrative services or health care coverage, or to arrange health care services for a population, and for which KFHP receives or may receive payment. The contract records all information about a relationship between a customer and KFHP with respect to mutual obligations and exceptions, as opposed to a contract version that records all information relative to a specific initial or renewal contract period.

2. An agreement that defines the terms and conditions set by Kaiser Foundation Health Plan, Inc., and the employer, which are documented in the Group Agreement.

Contract option

The health coverage choices that a health plan employer elects to offer its employees or individuals to purchase directly from Kaiser Permanente. Contract options allow an employer to define a set of benefits and rules for enrollees to choose from. An employer may offer more than one contract option to a group of members. Enrollees may choose one contract option or a permitted combination of contract options. Each contract may have one or more contract options, at least one of which is mandatory.

Contract version

The status (proposed, active, or canceled) of a contract and the dates during which that status is in effect. A new version is created when the contract is initially proposed and, thereafter, whenever the terms of the contract are changed. The terms may be changed at renewal time or when an amendment to the contracts is issued between scheduled renewals. Renewal time generally occurs annually, and the rates will usually change at this time. Other terms of the contract (e.g., eligibility rules or administrative practices) may also change.

Coverage

An insurance company term used to describe the extent of the protection provided.

Coverage effective date

The day and time at which insurance protection begins under a policy. The effective date is usually the first of the month or the date a person is hired.

Customer/employer

An individual, organization, regulatory organization, or association that signs or may sign (prospect) a contract with KFHP to provide health care benefits.

Dependent

A member whose relationship to a subscriber is the basis for membership eligibility and who meets the eligibility requirements as a dependent.

Disabled dependent—HMO users

A subscriber's or spouse's dependents who exceed the age limit for dependents are eligible for coverage if all of the following requirements are met: The dependent is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition that occurred prior to reaching the age limit for dependents, and receives 50 percent or more of their support and maintenance from you or your spouse. The subscriber must give the Health Plan proof of this dependent's incapacity and dependency within 60 days after we request it.

Disabled dependent—KPIC users

An overage dependent child who is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition that occurred prior to reaching the limiting age and who is 50 percent or more dependent upon the insured for support and maintenance may continue coverage as a disabled dependent subject to the eligibility certification requirements. Insured must submit proof of such incapacity and dependency to Kaiser Permanente Insurance Company (KPIC) within 60 days of insured's receipt of KPIC's notice of the child's attainment of the limiting age and subsequently as may be required, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Discrepancy

The difference between the amount due from an employer and the amount paid. An overage is payment of an amount over the amount due. A shortage is a payment of an amount less than the amount due.

Dues

The premium; the amount of the charges per coverage period that a contracting employer or subscriber pays for health plan coverage and benefits for subscribers and dependents.

Effective date

The date that services provided in the contract begin.

Eligibility requirements

Individuals are accepted for enrollment and continuing coverage only if they meet all eligibility and participation requirements established by the employer and agreed to by the health plan, and meet all applicable requirements set forth in the contract.

Eligibility rules

Employers have specific eligibility rules established by their contract with the Health Plan. The eligibility rules govern the coverage effective and termination dates of their members.

Employer Service Consultants (ESCs)

An advisor that represents the California Service Center, our membership administration department, in the field. ESCs work closely with your account management team, customers and the CSC to find solutions from our wide array of reporting options and billing and eligibility tools. Able to provide hands-on training sessions on our administration guidelines and online account services site.

End-stage renal disease (ESRD)

The stage of kidney impairment that is almost always irreversible and permanent, requiring a regular course of dialysis or kidney transplantation to maintain life. It is generally defined as five percent or less of normal kidney function remaining.

Enrollment reason

The reason for which a subscriber and dependents are enrolled. This may be done either by the individual signing up, by conditions of employment, or by another qualifying event.

Enrollment unit or billing unit

The customer-defined segment and associated facts (e.g., billing address, contact person) into which a health plan employer's or individual's transactions such as membership activity, payment allocations, and adjustments are grouped for billing purposes and reconciliation.

Evidence of Coverage (EOC)

Each EOC document that is included in the Group Agreement contains information about benefits, coverage, and other contract provisions that are pertinent to both the member and the employer. After enrollment, employers are responsible for providing subscribers with a copy of the EOC for which they are enrolled.

Family composition

The structure of the members within an account or unit. The family account can be composed of a subscriber, with or without one spouse, and with or without any number of dependents. In most cases, the number of family members affects the rate structure of the account.

Group Agreement

Our contract with our groups and members. It includes documents such as the *Evidence of Coverage*. These documents detail the coverage purchased by our groups and the eligibility rules, policies, and regulations that defines the provisions under which Kaiser Foundation Health Plan, Inc., agrees to provide health care coverage the provisions under which Kaiser Foundation Health Plan, Inc., agrees to provide health care coverage.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Certificates

Certificates of Creditable Coverage issued to terminated members and to active members upon request.

Health Plan

Kaiser Foundation Health Plan, Inc., a California nonprofit corporation.

ID card

Membership identification card that shows the member's medical record number used to identify medical records and membership information.

Kaiser Permanente Insurance Company (KPIC)

A for-profit subsidiary of Kaiser Foundation Health Plan, Inc., established in 1995, that allows Kaiser Permanente to offer employers the following:

- Our group model HMO product.
- Our HMO with a point-of-service indemnity option (POS).
- Traditional indemnity insurance through a Preferred Provider Organization (PPO).
- Out-of-area plans for members residing outside a Kaiser Permanente and PHCS Network service area (Out-of-Area Indemnity).

In other words, KPIC permits us to offer dual and multiple product offerings under the single administrative umbrella of Kaiser Permanente.

Loading

Any amount added to or subtracted from base rates to cover expenses and additional expected or unexpected variations in the cost of administering a contract.

Member

Individual who is eligible to receive medical services and benefits, is enrolled under the *Evidence of Coverage,* and for whom we have received applicable dues.

Member Service Contact Center

A contact center for members of Kaiser Permanente to ease in the access of care. The Member Services Contact Center is available 24 hours a day/7 days a week and can be utilized for non-urgent medical issues and answers to common questions.

Membership

The enrollment of a subscriber and/or dependents within an employer enrollment unit. Membership is a contractual agreement between an employer, a subscriber, and the Health Plan.

NSF

Non-sufficient funds. The way in which checks are designated when they are returned from the bank for non-sufficient funds.

Online Account Services (OAS)

Kaiser Permanente's online service, which allows employers to maintain membership, pay dues, and view eligibility and billing information. To access Online Account Services, go to **cas.kp.org**.

Open enrollment

The period, usually annual, during which employees and dependents can choose among any health plans offered by their employer.

Overage dependents

Dependents that have reached the maximum age limit for eligibility, as set forth in the contract, under the subscriber on a group account. These individuals may be eligible for continuation coverage.

Payment due date

The date by which payment is expected. In the case of a direct-reporting employer, a paid listing is due as well. Based on the billing schedule selected or determined during billing unit setup, the system will calculate the due date to be 30 days from the billing date.

Plan

Kaiser Permanente Health Plan.

Policyholder

The employer or trustee or other entity shown on the group policy.

Premium

The amount of dues that a contracting employer or subscriber pays for health plan coverage and benefits for subscribers and dependents.

Qualifying event

An event (e.g., marriage, birth, divorce, loss of coverage) that allows an individual to make an election change or add/delete dependents on his or her health coverage.

Rate change

An employer's rates are subject to periodic contractual change. Rate changes are usually annual, at contract renewal time. Members' rate changes could be based on an event such as a family addition or deletion.

Receivables

Estimated amounts of money earned but not received by the end of a specific month.

[1]Participating providers are part of the PHCS Network, a subsidiary of MultiPlan, Inc., and are accessible to members with the Point-of-Service Insurance plan or PPO Insurance Plan. The participating and non-participating provider options of these plans are underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc.

Reconciliation

The process of matching an employer's membership listing to Kaiser Permanente's membership listing, matching an employer's payment to Kaiser Permanente's expected payment, making appropriate adjustments so that both are synchronized, and reporting any discrepancies to the employer.

Remittance advice

A remittance advice/payment coupon should be sent with a payment and contains information relating to the payment, such as billing unit, billed amount, paid amount, and coverage period.

Retroactivity

A membership enrollment, termination, or change that is effective on a date prior to the current dues period.

Service area

The geographic area in which a person must live to enroll as a Health Plan member. It is currently defined through the use of ZIP codes and counties. Medicare enrollees must live in the Health Plan's service area.

Subscriber

1. A person on his or her own behalf and not by virtue of dependency status who, as either an employee or an employer or as a subscriber, is accepted for enrollment and continuing coverage, who meets all the acceptable eligibility requirements, who is enrolled, and for whom payment or a guarantee of payment has been received by the Health Plan.

2. A member who is eligible for membership on his or her own behalf and not by virtue of dependent status, and who meets the eligibility requirements as a subscriber.

TEFRA

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) extended Medicare payment limits to ancillary services, added Medicare coverage of hospice care, and allowed Medicare to sign risk contracts with HMOs and other competitive medical plans. It also limited Medicare's liability for people over age 65 who are still working, by making their employer's insurance primary.

Termination

The act of ending a member's health care coverage through Kaiser Permanente. Members are terminated for nonpayment of dues, fraud, loss of employer coverage, and moving out of the Kaiser Permanente service area. The term is also used to describe the ending of a health plan contract for an employer.