KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

GROUP ADMINISTRATIVE GUIDE

for small businesses

KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

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Table of contents

EVERYTHING YOU NEED TO ADMINISTER YOUR GROUP HEALTH PLAN IS RIGHT HERE

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SECTION 1

HOW TO REACH US

Online services

account.kp.org features

- Navigating account.kp.org (specific guidance of employer portal).
- How to view and make online payments, enroll members, manage users, view documents, provide guidance in setting up email notifications, etc.
- Assign/change/identify primary group administrators or go to this link to complete request: **https://account.kp.org/business/pga-form**.
- Send access codes.
- Troubleshoot and/or create IT tickets for errors.

kp.org services

- View and schedule most appointments.
- See most test results.
- Email your doctor or a member of your care team.
- View and pay bills for services.
- Order prescriptions.

For employers, visit **account.kp.org**.

account.kp.org support: **1-866-575-3562**

8 a.m. to 5 p.m. (Pacific time)

Monday through Friday

For members, visit **kp.org**.

Member Services **kp.org** support: **1-800-813-2000**

Billing and eligibility

- Billing questions.
- Account balance.
- Account audits.
- Request a copy of the group premium bill.
- **account.kp.org** for online group billing.
- Employer- or broker/producer-initiated eligibility requests.

Consolidated Service Center (CSC)

Phone: **1-866-868-7220**

Fax: **1-866-311-5974**

Email: **csc-den-roc-group@kp.org**

Hours: 6 a.m. to 5 p.m. (Pacific time)
Monday through Friday

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Premium payments

- Make one-time payments or set up recurring payments on account.kp.org.

As necessary options:

- Wire transfer.
- Check through the mail.

Online (preferred):
account.kp.org

Wire transfer to our bank:
Wells Fargo
111 SW Fifth Ave., Suite 1090
Portland, OR 97204
Phone: **213-614-3061**
Account name:
Kaiser Foundation Health Plan, Inc.
Account number:
4128822210
ABA/routing number: 121000248

Mail:
Kaiser Foundation Health Plan
of the Northwest
P.O. Box 34178
Seattle, WA 98124-1178

Unresolved issues, escalations

- Concerns about member access to care.
- Benefit and claim payment issues.
- Unresolved matters, discrepancies, or issues.

Employer and Broker Services (EBS)

The Employer and Broker Services (EBS) team will help resolve any urgent or escalated service issues.

Phone: **503-813-3613**
1-866-246-3613

Email: nw.kp.ebs@kp.org

Hours: 8 a.m. to 5 p.m. (Pacific time)
Monday through Friday

Reports and *Evidence of Coverage (EOC)*

- Request a copy of the group contract and *EOC*.
- Group Agreement Portal and *EOC:* https://oneview.oneildata.com/KPNWGroupDoc.
- Overage disabled dependent questions and forms.
- Eligibility change requests outside of your group's retroactivity limit.
- Premium delinquency questions and support.

Membership Administration

Phone: **503-813-4224**

Fax: **1-855-524-5257**

Email: nw.membership.administration@kp.org

Hours: 8 a.m. to 4:30 p.m. (Pacific time)
Monday through Friday

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Account management

- Open enrollment meetings.
- Renewals and policy changes.
- Eligibility and underwriting.
- Plans and benefits.
- Enrollment materials.
- Escalated and/or unresolved issues or inquiries.
- Group contact changes.

Account manager: _____

Email: _____

Phone number: _____

Associate account manager: _____

Email: _____

Phone number: _____

Address: 500 NE Multnomah St.
Portland, OR 97232

Department phone: **503-813-2630, option 3**

Fax: **1-877-237-5548**

Member Services

- Select a primary care provider.
- New member care.
- Benefit questions.
- Claims inquiries.
- Grievances and appeals.
- Order a replacement ID card.

Phone: **1-800-813-2000**

1-866-616-0047 for Kaiser Permanente Plus™, Added Choice® and PPO Plus® members

1-800-813-2000

Language interpretation services:
1-800-324-8010

TTY: **711**

5500 Reports

- Premiums received.
- Sales and base commissions for brokers/producers and/or agents.
- Broker/producer/agent contact information.
- Employer Identification Number.
- Covered persons on the last day of your contract year.

5500 Central Team

Email: 5500-central-team@kp.org

Your important account information

Group name/dba: _____

Group number: _____ Subgroup numbers: _____

Bill group: _____ Renewal date: _____ Open enrollment month: _____

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SECTION 2

INTRODUCTION TO YOUR ADMINISTRATIVE GUIDE

Welcome to the *Group Administrative Guide for Small Businesses.* This is your guide to administering Kaiser Foundation Health Plan of the Northwest (KFHPNW) benefit plans. Think of this as your go-to guide.

We designed this guide to help make your life easier. You will find information about contract renewal, enrollment, member cancellations, and billing, along with the forms you need to manage your plan.

MAKING THE MOST OF YOUR DECISION TO PARTNER WITH US

You have made a significant investment in your business by providing your employees with access to our integrated medical care delivery system. You will get a much better return on that investment by making sure you and your employees get the full value out of everything we offer — including emailing a doctor, scheduled video or phone appointments, e-visits,[1,2,3] and 24/7 virtual care.[4,5]

Providing you with excellent customer service is always our priority. If you can't find the information you are looking for, or if you have any questions about this guide, please contact your account manager.

Thank you for choosing Kaiser Permanente. Here's to a long and healthy partnership.

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, talk with your sales executive or account manager or go online to account.kp.org.

[1]For high deductible health plan members, e-visits, phone visits, and video visits are subject to your plan's annual deductible.

[2]When appropriate and available.

[3]To have a video visit, members must be registered on kp.org and have a camera-equipped computer or mobile device. If you travel out of state, phone and video visits may not be available due to state laws that may prevent doctors from providing care across state lines. Laws differ by state.

[4]These features are available when you get care at Kaiser Permanente facilities.

[5]Applicable cost shares will apply for services or items ordered during an e-visit.

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SECTION 3

ADMINISTERING YOUR GROUP HEALTH PLAN

GROUP NUMBER, SUBGROUP NUMBER, AND BILL GROUP

Group number — 5 digits

Subgroup number — 3 digits

Bill group — 2 letters

Region number — 10

ONLINE (PREFERRED METHOD)

Your account has a unique 5-digit group number. In addition, you have one or more subgroup numbers that identify your selected plans and contracts. You will also have one or more bill groups (generally AA or AB). With this data, you can enroll and update membership, view your contracts and other plan documents, order ID cards, and much more — all through **account.kp.org**.

PAPER ENROLLMENTS (NON-PREFERRED METHOD)

You must include your group number, subgroup number, and bill group on all enrollment forms. This is particularly important if you have multiple contracts or subgroups. Your group number should be included on all documents, such as correspondence and premium payments. Providing these numbers on the appropriate forms helps us process your membership requests and payment allocation quickly and accurately.

TIMELY REPORTING AND CORRESPONDENCE

Accurate, timely reporting of your Kaiser Permanente membership enrollments and changes, and making payments on time, helps ensure that your employees and their family members are properly enrolled. It also ensures that their coverage remains prepaid and that newly enrolled members and family members receive their Kaiser Permanente member identification cards in a timely manner.

CONTRACT PERIOD/RENEWAL

Your group benefit plan(s) and rates are issued for a 12-month term beginning on the effective date of coverage.*

You or your broker/producer will receive your renewal offer at the agreed-upon timeline in advance of the renewal effective date, usually 90 days before your renewal date. For more information on the renewal process, please see Section 7 of this guide.

*Exceptions include a dental plan added after the start date of an employer's medical plan. In this case, the dental contract end date will be the same as the end date of your group's medical plan.

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GROUP TERMINATION NOTICE

Your group may terminate their group health plan agreement by submitting prior written notice and remitting premium for the period through the termination date. Notices should be submitted in advance in writing to the account management team including requested date and reason for termination.

CHANGE OF COMPANY OWNERSHIP

We make it easier to keep your employees covered, even in a time of organizational change. If your company's ownership changes, contact your broker/producer or account manager. If your company changes ownership and/or if it is involved in a merger or acquisition, your plan may need to be re-rated depending on how your employee population changes.* You may request a one-time special open enrollment if this situation applies to you. Contact your account manager for more information.

MEDICAL RECORD NUMBER

Members are assigned a unique 8-digit medical record number linked to their medical records and plan information. This number is theirs for life. For instance, if they were a Kaiser Permanente member 20 years ago and rejoin next year, they will have the same medical record number. Whenever possible, the medical record number should be included on all member documents and correspondence.

EMPLOYEE AND FAMILY MEMBER ENROLLMENTS AND CHANGES

Visit **account.kp.org** to manage your Kaiser Permanente business online. With 24/7 access, you can manage employee coverage, view your billing history, make payments, and adjust who has access to administrate your group's records. These tools offer the fastest way to add or remove coverage and update an employee's demographics, with most changes taking place instantaneously.

Submitting enrollments:

Online (preferred): **account.kp.org**
Email: **csc-den-roc-group@kp.org**
Fax: **1-866-311-5974**

BEFORE ENROLLMENT

Enrollment packets containing employee-specific benefit information are available from your account management team.

*The Change of Ownership Form does not assign the existing contract to the new owner. The buyer and seller may want to get legal counsel about contract changes.

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OPEN ENROLLMENT

This is the enrollment period for eligible employees and their eligible family members who did not enroll when they initially became eligible. Additionally, members who are already enrolled may make plan changes during open enrollment. These employees must complete and sign a Kaiser Permanente Group Employee Enrollment/Change Form during the open enrollment period. Delays may prevent enrollment. Enrollment forms are not needed for employees or their family members who are already enrolled in your plan and making no changes.

If you offer more than one plan, employees will need to indicate their plan selection on the enrollment form. The group administrator should fill out the 2-in-1 Employee Benefit Designation Form or the 3-in-1 Employee Benefit Designation Form. Employees will need to sign the form under their name in the column with their plan choice.

NEW HIRES/PROBATIONARY PERIOD (WAITING PERIOD)

New employees who meet the minimum hourly requirement may enroll in accordance with their probationary period. You must provide Kaiser Permanente with an enrollment date for each new subscriber.

To comply with the Affordable Care Act, the maximum length of a probationary period is not more than exactly 90 days from date of hire. If a new hire does not enroll at the end of the probationary period, the next available enrollment date is the annual open enrollment, unless the employee later qualifies for a special enrollment period (see below). Waiving the probationary period for key employees is not permitted, unless they become eligible for the special enrollment period.

SPECIAL ENROLLMENT RIGHTS FOR EMPLOYEES AND FAMILY MEMBERS

Employees who decline coverage for themselves or any eligible family member because they are enrolled in another group health plan may have another opportunity to enroll before the next open enrollment. This is known as a special enrollment period, which grants employees and eligible family members the same permissions they would have during open enrollment. Certain life events may also qualify the employee and family members for a special enrollment period.

On or before the date you offer an employee the opportunity to enroll in the plan, you should provide a description of the special enrollment rules. You can use this example:

Employee notice

If you decline enrollment for yourself or your family members (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your family members in this plan in the future, provided you request enrollment within 30 days after your other coverage ends (or 60 days if due to loss of eligibility for Medicaid). In addition, if you have a new family member as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible family members, provided you request enrollment within 30 days after the qualifying event.

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QUALIFYING EVENTS FOR SPECIAL ENROLLMENT OF A SUBSCRIBER AND ELIGIBLE FAMILY MEMBERS

Employees and family members may qualify for special enrollment under certain conditions, such as:

- Loss of eligibility under the other group health plan due to legal separation, divorce, death, reaching the age limit for dependent children, termination of employment, or reduction in hours.
- Loss of coverage under the other group health plan because the employer contributions have been terminated.
- Exhaustion of COBRA or State Continuation coverage.
- Loss of Medicaid coverage.
- Marriage or registered domestic partnership.
- Birth of a child.
- Adoption or placement for adoption.
- Court or administrative order.
- Re-employment after military service.

EFFECTIVE DATE OF COVERAGE FOLLOWING A QUALIFYING EVENT

Employees must notify you of their request for special enrollment within 30 days of the qualifying event (60 days if due to loss of eligibility for Medicaid). The effective date of coverage is the first of the month following the qualifying event. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

SUBMITTING FORMS FOR SPECIAL ENROLLMENT

To enroll someone outside your usual open enrollment period, use **account.kp.org** or send us a completed Group Employee Enrollment/Change Form for the employee or family member. Be sure to mark the appropriate reason for the enrollment outside your open enrollment period.

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EMPLOYEE ENROLLMENT

Submit enrollment forms to:

Online (preferred): account.kp.org
Email: csc-den-roc-group@kp.org
Fax: **1-866-311-5974**

USING THE GROUP EMPLOYEE ENROLLMENT/CHANGE FORM

Eligible employees who wish to join Kaiser Permanente must complete our Group Employee Enrollment/Change Form for Washington or Oregon. This form provides us with the information we need to enroll your employees and their eligible family members. When we process enrollments, we enroll your employees and eligible family members with the effective date supplied on the Group Employee Enrollment/Change Form.

Please ensure your eligible employees understand and complete all fields on the form. Be sure that completed enrollment forms are returned to the appropriate area in your organization or to an appointed third-party administrator for submission to Kaiser Permanente. To ensure accurate processing of your forms, your group number, subgroup number, and bill group must be on all forms.

Enrollment forms must be submitted to the Consolidated Service Center (CSC) by the employer or third-party administrator. Enrollment forms are not accepted directly from employees.

ENROLLMENT SUBMISSION REQUIREMENTS

The preferred method for enrollment submissions is through **account.kp.org**. All membership transaction requests must be submitted in writing on a Kaiser Permanente Group Employee Enrollment/Change Form for your state, unless your group processes enrollments through our **account.kp.org** option (see Section 4), submits an electronic file, or remits eligibility by email. This form is a legal document and must be regarded as such. The Group Employee Enrollment/Change Form identifies all the required information we need to process your membership enrollment.

Enrollments cannot be processed until the CSC receives a completed Group Employee Enrollment/Change Form. To ensure all enrollment requests are processed, you should carefully review all information for accuracy and completeness before submitting a form.

Email or fax completed forms to the CSC at the appropriate address or fax number in Section 1 of this guide. Enrollment changes cannot be accepted by telephone.

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AVOIDING PROCESSING DELAYS

To avoid delays in processing, be sure that all sections of the Group Employee Enrollment/Change Form are complete and legible. Also, be sure that additions and deletions to your account are submitted within the retroactivity guidelines described in your *Group Agreement.*

Submit enrollment forms as soon as you receive them from your employees. Delays in processing are often due to missing and inaccurate information. Use the following checklist to help ensure the necessary information is complete and correct:

- Name of employee (and each family member in appropriate section).
- Full address.
- Date of birth for employee and each family member.
- Gender.
- Relationship code.
- Group name/Group number (5 digits).
- Subgroup number (3 digits).
- Bill group (2 letters).
- Effective date.
- Medical record number (if known) for employee and each family member.
- Employee signature.

AFTER ENROLLMENT

After employees enroll, we will send them important information about their benefits. This includes:

- Kaiser Permanente ID card for each member of the family (within 7 to 10 business days). See ID card examples beginning on page 16.
- Kaiser Permanente *Evidence of Coverage (EOC),* which explains in detail the benefits provided by the plan(s) in which they have enrolled. Within 45 days from the date coverage is effective, we will send new members a postcard providing the option for them to view the *EOC* electronically or request a printed copy.

MEMBER CANCELLATIONS

We must be notified of cancellation for a member or family member(s) in writing from the group administrator as soon as possible, but no later than within the time period for retroactive cancellations as stated in your *Group Agreement (you may not cancel a Senior Advantage member retroactively).* Medicare terminations need to be reported 30 days in advance of the termination date.

Online (preferred): **account.kp.org**
Email: **csc-den-roc-group@kp.org**

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You can process membership changes online. See Section 4 of this guide for information. To request a cancellation in writing, use the Membership Changes Form provided with your billing statement or the Member Cancellation of Coverage Form in Section 11.

Note: When an employee membership is canceled, the entire family account is terminated.

WAIVING COVERAGE

Members can waive group coverage if they have other group coverage through their spouse or coverage through a qualifying plan such as Medicare or Veterans Affairs. To learn more about valid waivers, which forms to use, and notification requirements, please refer to your "Rating and Underwriting Assumptions" document for the correct plan year and state.

Note: Waiving coverage does not cancel a member's coverage. To cancel a member's coverage, refer to the Frequently Asked Questions — Administering Your Group Health Plan section, under "Termination."

FAMILY MEMBER ELIGIBILITY

When a family member is enrolled, the relationship to the member must be clear. Please refer to the "When You Can Enroll and When Coverage Begins" section of your *Group Agreement* to determine the time frame in which members must notify us to add a newborn, newly adopted child, new spouse, and other family members to their group coverage. Family members who may be eligible to enroll under the member include:

Spouse (or eligible domestic partner)

Child
A person who is under the *dependent limiting age* shown in the Benefit Summary and who is any of the following:

- Child of subscriber, spouse, or eligible domestic partner.
- Enrolled family member's newborn child (see "Newborns" in this section for information).
- Child adopted or placed for adoption with subscriber, subscriber's spouse, or subscriber's domestic partner.
- Any other person for whom the subscriber or spouse is a court-appointed guardian.
- Child placed for foster care with subscriber, subscriber's spouse, or eligible domestic partner.

Overage dependent
An enrolled dependent who reaches the maximum age for dependent status (last day of the month of their 26th birthday month) will be terminated from the subscriber's account.

GRANDCHILDREN

Effective for contracts issued or renewed January 1, 2012, and later, children born to an eligible family member (such as grandchildren) are not eligible for coverage beyond the state-mandated days unless the subscriber or subscriber's spouse adopts them or becomes their court-appointed guardian.

NEWBORNS

A child born to a subscriber (or subscriber's spouse/domestic partner) at a Kaiser Permanente facility is automatically covered under the mother's plan for the state-mandated days. If the child is born at a non–Kaiser Permanente facility, then either the subscriber must call Member Services at **1-800-813-2000** or the group/group administrator must contact our CSC to request the child be added for the newborn coverage.

Email: csc-den-roc-group@kp.org
Fax: **1-866-311-5974**
Online: account.kp.org

Mandated coverage dates will vary based on what state your group resides in.

Oregon
Newborns are covered from the moment of birth for the first 31 days of life. For coverage to continue beyond this 31-day period, the subscriber should submit an enrollment application to their group within 31 days after their child's birth. Premium is billed for enrolled newborns, first of the month following date of birth.

Washington
Newborns are covered from the moment of birth for the first 21 days of life. For coverage to continue beyond this 21-day period, the subscriber should submit an enrollment application to their group within 60 days after their child's birth. Premium is billed for enrolled newborns, from date of birth, prorated.

Note: To continue coverage beyond the mandated coverage dates, we must receive a completed Group Employee Enrollment/Change Form before the end date to avoid a coverage gap; you can also submit the change via account.kp.org.

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DEVELOPMENTAL OR PHYSICAL DISABILITY

A person of any age who is primarily dependent upon the subscriber or the subscriber's spouse for support and maintenance is eligible if the person is incapable of self-sustaining employment because of developmental disability, mental illness, or physical disability that occurred prior to the person reaching the *dependent limiting age* on the Benefit Summary, if the person is any of the following:

- Subscriber's child.
- Spouse's or eligible domestic partner's child.
- Child adopted by the subscriber, subscriber's spouse, or subscriber's eligible domestic partner.
- Child for whom subscriber, subscriber's spouse, or subscriber's eligible domestic partner has assumed legal obligation in anticipation of adoption.
- Any other person whom the subscriber, subscriber's spouse, or subscriber's eligible domestic partner is a court-appointed guardian and was a court-appointed guardian before the person reached the overage dependent limit.

The subscriber must provide us with proof of incapacity and dependency annually if we request it, but only after a 2-year period following attainment of the general *dependent limiting age*. We will send a request for information to the member asking the member to verify that the family member continues to meet requirements of this provision. The member must complete, sign, and return the form within 31 days of our request to the contact stated on the form to ensure that the family member's coverage remains in effect. To obtain required documents, please contact Member Services at **1-800-813-2000.**

COURT OR ADMINISTRATIVE ORDER

In the event of a court or administrative order, a child who meets the eligibility requirements in the *Group Agreement* may be added as a family member outside the group's open enrollment period, or at a time other than when the subscriber was first eligible to enroll. This is considered a qualifying event for enrollment. If such an order is received, the group or administrator must inform us immediately, letting us know who must be enrolled and the effective date of the enrollment. We may request a copy of the court or administrative order.

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MEMBER ID CARDS

The member ID card includes the member's name, medical record number, and date of birth. It also has important emergency information and telephone numbers on the back. Members are asked for their medical record number when they call for medical advice, for an appointment, or with questions about their coverage. When receiving care at one of our medical facilities, we ask members to have access to their ID cards by using the digital copy of their ID card on the Kaiser Permanente app* or bringing their physical copy to their appointment. The ID card is for member identification and is presented whenever the member receives care. If the member does not have it, their identification can be verified with their medical record number and a valid photo ID.

TEMPORARY ID CARDS

Until new members receive identification cards in the mail, they may make a copy of their enrollment form for temporary identification. Member Services can also create a temporary member ID card. ID card information may also be accessed on the Kaiser Permanente app.

REPLACING ID CARDS

Lost or stolen ID cards can be ordered by calling Member Services at **1-800-813-2000**. (For TTY, **711**. For language interpretation services, **1-800-324-8010**.) Members can also order a replacement card by signing in to **kp.org**. Select "Coverage & Costs," then "ID card help" to order a replacement ID card.

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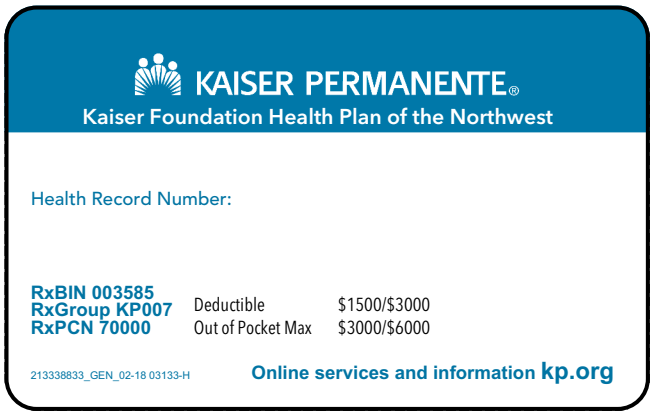
*The digital version is not available for all types of member ID cards.

SAMPLES OF MEMBER ID CARDS

Traditional and deductible medical plans and traditional dental plans

(FRONT)



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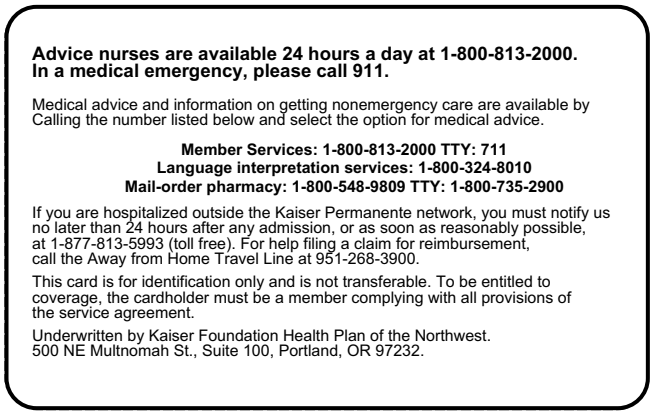
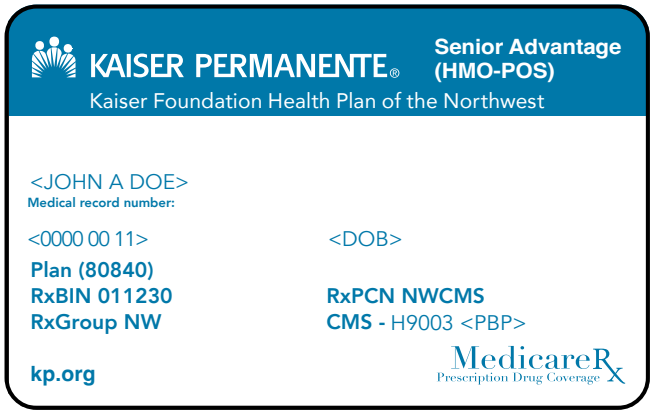


Senior Advantage (Medicare) with pharmacy

(FRONT)



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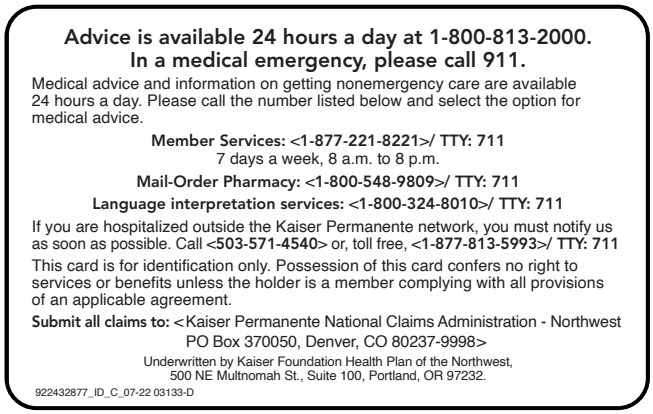

Senior Advantage (Medicare) without pharmacy

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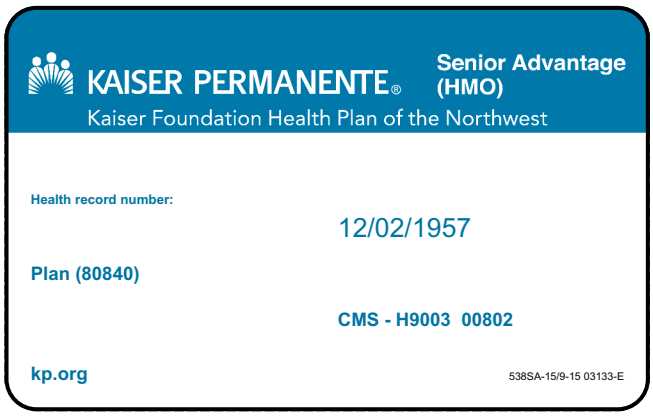

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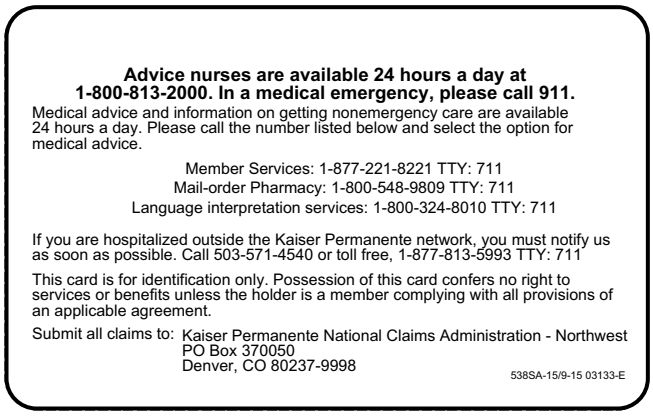

Kaiser Permanente Plus™

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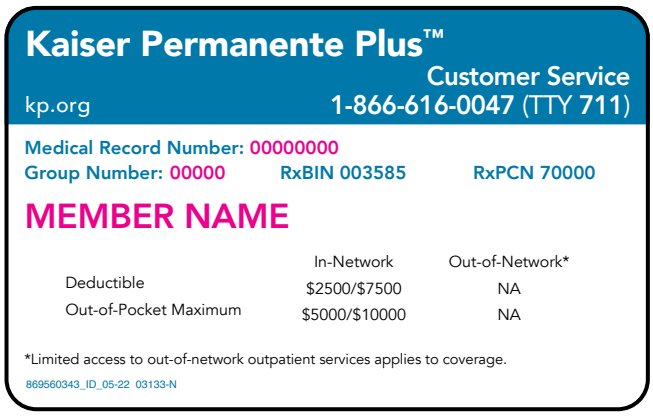

Kaiser Permanente Plus™

kp.org

Customer Service
1-866-616-0047 (TTY 711)

Medical Record Number: 00000000
Group Number: 00000 RxBIN 003585 RxPCN 70000

MEMBER NAME

	In-Network	Out-of-Network*
Deductible	$2500/$7500	NA
Out-of-Pocket Maximum	$5000/$10000	NA

*Limited access to out-of-network outpatient services applies to coverage.

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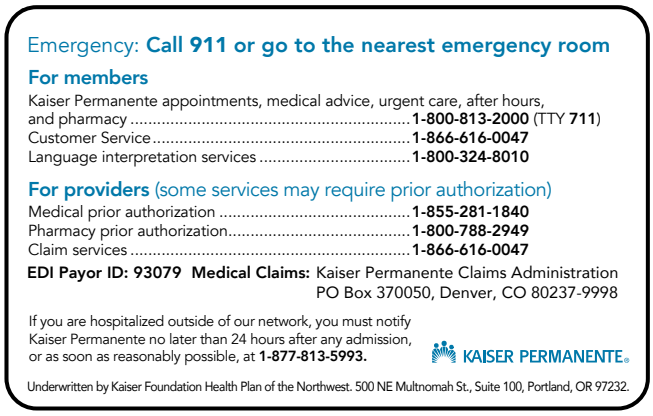

Emergency: **Call 911 or go to the nearest emergency room**

For members

Kaiser Permanente appointments, medical advice, urgent care, after hours, and pharmacy ..... **1-800-813-2000** (TTY **711**)
Customer Service **1-866-616-0047**
Language interpretation services **1-800-324-8010**

For providers (some services may require prior authorization)

Medical prior authorization **1-855-281-1840**
Pharmacy prior authorization **1-800-788-2949**
Claim services **1-866-616-0047**

EDI Payor ID: 93079 Medical Claims: Kaiser Permanente Claims Administration
PO Box 370050, Denver, CO 80237-9998

If you are hospitalized outside of our network, you must notify Kaiser Permanente no later than 24 hours after any admission, or as soon as reasonably possible, at **1-877-813-5993.**

KAISER PERMANENTE®

Underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.

Added Choice® with First Choice Health and MedImpact pharmacy

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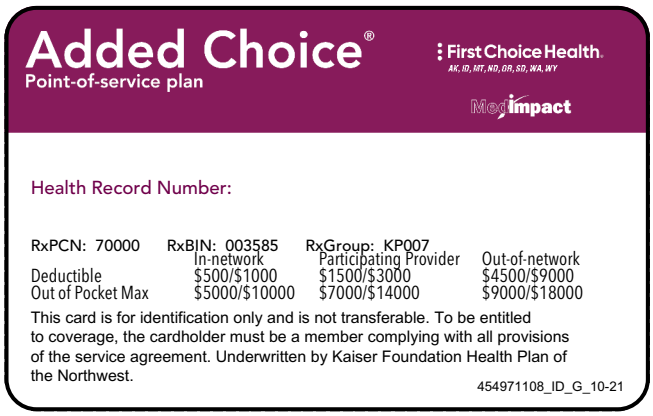

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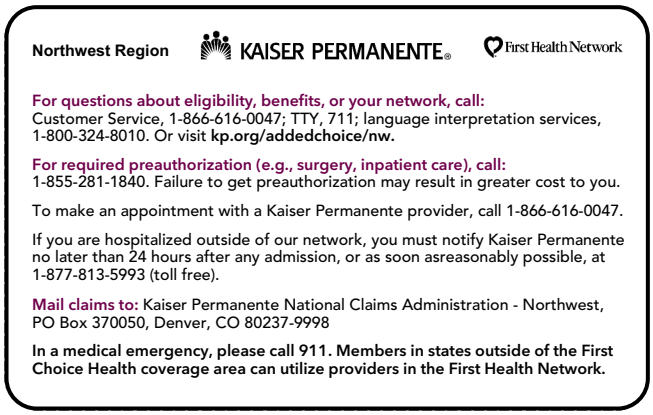

Added Choice® with First Choice Health

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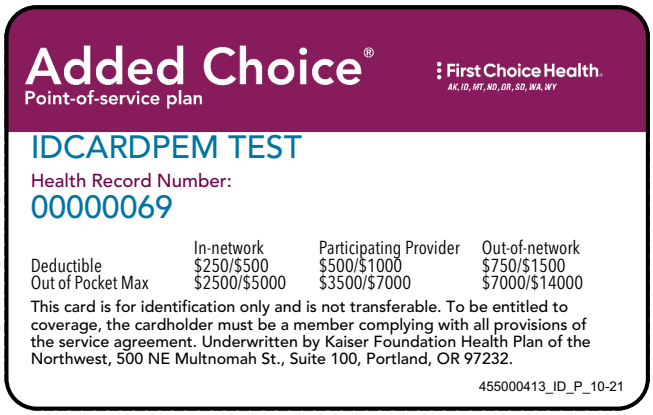

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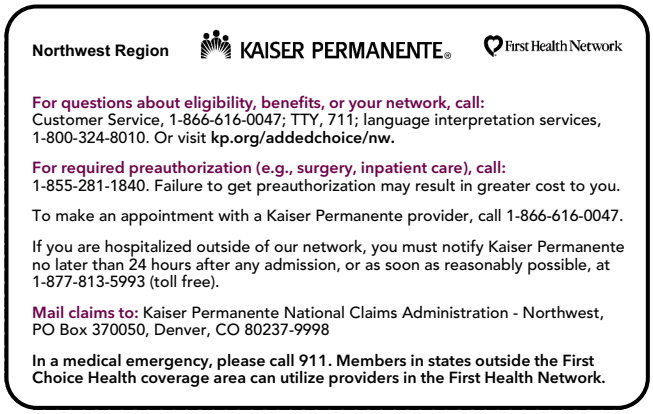

PPO Plus®

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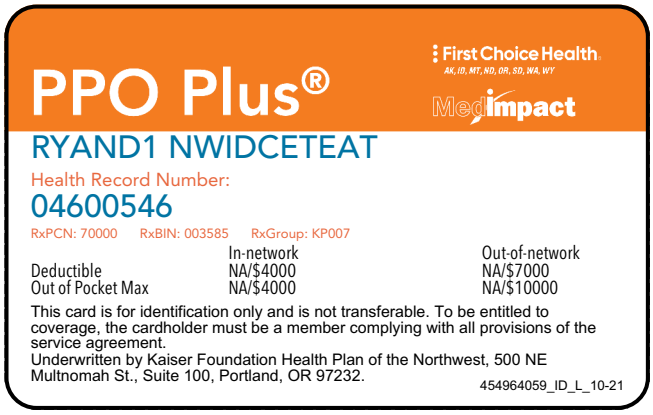

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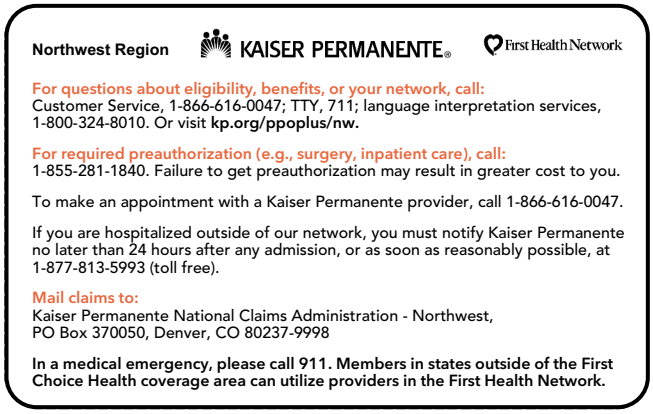

PREMIUM BILLING

MONTHLY PREMIUM DUE DATES

Your *Group Agreement* requires you to prepay the monthly premium for your enrolled member(s). **Premiums are due the last day of the month before the month of coverage.** For example, premiums for April are due March 31. If payment is not received, there is a risk of delinquency actions, which may include cancellation of your account.

BILLING STATEMENT AND REMITTING PAYMENT

You can find copies of your billing statements on **account.kp.org**. The monthly billing statement includes the coverage period being billed, membership and payment transactions processed for an activity period, and the total amount due. Generally bills are generated by the 10th of the month preceding the coverage effective month. To ensure that eligibility changes are reflected on your bill, be sure to have your changes submitted 10 days in advance of your billing date.

Note: If your changes are not reflected on your invoice, you can pay as billed. On the following billing statement, we will correct the amount owed. If there is any overpayment on your account, it will appear as a credit on the next month's billing statement. If a balance is owed, it will also appear on the next month's billing statement.

PAYMENTS VIA ACCOUNT.KP.ORG (PREFERRED METHOD)

Premium payments can be made online through **account.kp.org**. You can make one-time payments, set up and manage recurring payments, and much more.

FEATURES OF ACCOUNT.KP.ORG

Using **account.kp.org**, you can:

- Manage members by enrolling, terminating, and updating group membership.
- Manage payments by making one-time payments, setting up or managing recurring payments, and viewing payment history and transaction details.
- View and print premium payment invoices.
- Order ID cards.
- Manage email notification preferences for e-receipt and bill notifications.
- View group documents.

Note: If you have an active broker/producer of record, they may have the same online membership capabilities as you do for enrolling and maintaining membership. As a reminder, the primary group administrator for your account can always manage account access.

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SIGN UP

To learn more about account.kp.org, click here.

To sign up:

1. Go to **account.kp.org**. Then click "Register."
2. Fill out and submit the form online.
3. Allow 7 business days for us to set up your online account.

You will be emailed a user ID. For additional information, please call our web support team at 1-866-575-3562.

Note: In order to maintain premium and eligibility integrity, DO NOT use **account.kp.org** for submitting changes or payments if you submit eligibility through an electronic file.

ACH PAYMENTS AND WIRE TRANSFERS

You may arrange for Automated Clearing House (ACH) payments or wire transfers. ACH payments are automatic electronic transfers of funds between your financial institution and ours. Wire transfers are electronic payments you initiate.

Setting up an ACH payment or wire transfer:

- Contact your bank. You will need to provide Kaiser Permanente's bank information:

  Wells Fargo
  111 SW Fifth Ave.
  Suite 1090
  Portland, OR 97204
  213-614-3061

  Account name: Kaiser Foundation Health Plan, Inc.

  Account number: 4128822210

  ABA routing number: 121000248

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- **Wire transfers** — Posting time is 1 or 2 business days to fully process. To make sure your wire transfer is on time, please tell your bank to provide the following in the payment detail. This should be given first, before any other information, to make sure it is not truncated during processing. Ask your bank to provide:

  – Your group number and bill group number.

  – Your group name as it appears on your Kaiser Permanente contract.

- **ACH payments** — Posting time is 2 or 3 business days. If you are making an ACH payment, please use the "CCD plus" format designed to meet standards of Electronic Data Interchange systems. Please ask your bank to provide your group number first, followed by your group name in the "payment detail ID/ name" field of your ACH payment.

CHECK OR MONEY ORDER BY MAIL (NON-PREFERRED METHOD)

If payments through **account.kp.org**, ACH, or wire transfer are not available, you may send premium payments via a check or money order through the mail. Prepare a check or money order for the amount due. Make the check payable to Kaiser Foundation Health Plan of the Northwest (or KFHPNW). Include your group number, bill group, and region number (10) in the memo section (this information is located on your billing statement). Fill out the remittance slip on the billing statement, detach it, and include it with your check. If you are paying for multiple bill groups, be sure to include documentation that breaks out the amount for each bill group.

- **By mail**

  Mail your check, 5 to 7 business days before the due date, to:

  Kaiser Foundation Health Plan of the Northwest
  P.O. Box 34178
  Seattle, WA 98124-1178

  Note: Do not send enrollment forms or changes to this address. Kaiser Permanente facilities will not accept payments in person.

RETURNED CHECKS

We will process your check one time. Your financial institution will inform you if you have a check returned for insufficient funds. If this occurs within your grace period and your account is delinquent, we may cancel your account.

COUNTER DEPOSITS

Please do not make counter deposits at a Wells Fargo bank. The bank has no way of telling us whom the payment is for.

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DELINQUENCY

Your contract requires you to prepay the monthly coverage premium for your enrolled member(s). Premiums are due the last day of the month prior to the month of coverage.

REINSTATEMENT OR REENROLLMENT FOLLOWING A CANCELLATION DUE TO NONPAYMENT

LATE PAYMENT PENALTIES

As a prepaid health plan, Kaiser Permanente expects customers to pay the full and appropriate premium for each enrolled member by the first day of the coverage month. If a customer pays after the 15th day of the coverage month, a payment is considered late. There can be a penalty for late payments.

REINSTATEMENT

If your group policy is canceled because of nonpayment, you may be eligible to reinstate with no lapse in coverage. To be eligible, you cannot exceed 2 nonpayment cancellations in a 12-month period or 2 insufficient-fund checks in a 6-month period. Reinstatement must take place by the last day of the month that you receive your cancellation letter. To reinstate your policy, payment can be made over the phone at **1-888-808-5222.** Cashier's checks and wire transfers would only be requested for nonsufficient funds payments.

REENROLLMENT

If you are not eligible for reinstatement, you may be eligible to reapply for coverage after paying off collections and back premiums due. Applying for a new plan will require that you submit a new employer application and all supporting documentation to requalify for group coverage. If qualified, a new 12-month *Group Agreement* and new rates would apply. Contact your producer or account manager for more information.

ACCOUNT STATUS INQUIRIES

You may visit **account.kp.org** to review your account including any delinquency notices and status. You may also call the CSC at **1-866-868-7220.**

PAYMENT OPTIONS

Please see the "Premium billing" section.

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FREQUENTLY ASKED QUESTIONS — ADMINISTERING YOUR GROUP HEALTH PLAN

ACCOUNT AUTHORIZATION

Q: Can I authorize people to access and administer my group account?

A: You can assign an employee as a secondary contact. To assign a secondary contact, please complete the Employer Administrative Changes Form and fax it to **1-877-237-5548.**

BILLING AND ENROLLMENT

Q: Whom do I contact for billing and enrollment questions?

A: You may use account.kp.org to check the enrollment status of your employees, verify bills, and confirm receipt of payment. Just sign in and click on "Manage Account."

You may also contact the CSC by email at csc-den-roc-group@kp.org or by phone at **1-866-868-7220.**

BENEFITS

Q: Where can I find information about my group's benefits?

A: Please see your *Group Agreement,* view group documents on account.kp.org, or contact your Kaiser Permanente account management team at **503-813-2630** (option 3).

Q: Whom do my employees call if they have benefit questions?

A: Subscribers and their family members can view medical plan information and plan documents in the "Coverage & Costs" tab after signing in to their kp.org account. Alternatively, they may call Member Services at **1-800-813-2000 (1-866-616-0047** for Kaiser Permanente Plus™, Added Choice® and PPO Plus® members). For TTY, **711.** For language interpretation services, **1-800-324-8010.**

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CONTRACTS AND RATES

Q: How can I get a copy of my *Group Agreement?*

A: Postcards are mailed to the group contact within 45 days of your policy renewal. The postcard contains a bar code and directions for the group contact to register on the Group Agreement Portal, which allows you to view or request *Group Agreements* online. You may also contact NW Membership Administration at **503-813-4224** or **nw.membership.administration@kp.org**.

Q: Where can I find my group's rate?

A: You can find your group premium rates by viewing your monthly invoices or transaction history on **account.kp.org** or calling your account management team at **503-813-2630** (option 3).

DATES

Q: How can I find out my group's renewal or anniversary date?

A: Please see your *Group Agreement* or call your account management team at **503-813-2630** (option 3).

FAMILY MEMBERS

Q: How do I add or delete family members?

A: To add or delete a family member, visit **account.kp.org** and select your company's region, then click on "Manage Account." See Section 4 for more information.

To add a family member, you may also complete the Group Employee Enrollment/Change Form and fax it to the CSC at **1-866-311-5974** or email a copy to **csc-den-roc-group@kp.org**. To delete a family member, you may complete the Member Cancellation of Coverage Form and fax it to the CSC at **1-866-311-5974** or email a copy to **csc-den-roc-group@kp.org**.

DENTAL

Q: How and when can I add dental coverage?

A: You can add dental coverage on your group's anniversary date or the first of any month during the plan year. For dental benefits and rates, call your broker/producer or account management team at **503-813-2630** (option 3).

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ENROLLMENT/NEW HIRES

Q: How do I enroll a new employee?

A: You may enroll new employees electronically. Visit **account.kp.org** and use the "Manage Members" tab. The employee must provide a signed and completed Group Employee Enrollment/Change Form for your records. Alternatively, you can mail the completed and signed form to:

Online (preferred): **account.kp.org**
Email: **csc-den-roc-group@kp.org**

Mail:
Kaiser Permanente
P.O. Box 23127
San Diego, CA 92193-3127

Be sure to include the following on the enrollment form:

- Name of employee (and each family member in appropriate section).
- Full address.
- Date of birth for employee and each family member.
- Gender.
- Relationship code.
- Group name/Group number (5 digits).
- Subgroup number (3 digits).
- Bill group (2 letters).
- Effective date.
- Medical record number (if known) for employee and each family member.
- Employee signature.

Q: How do I find out if you have received an enrollment form?

A: You may verify that your enrollment has been completed through **account.kp.org** after 8 business days.

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TERMINATION

Q: How do I terminate a member's health coverage?

A: You may terminate coverage electronically: Visit **account.kp.org** and select your company's region, then click on "Manage Account." Member cancellation requests must be received within 60 days of the date the employee is terminated. We recommend listing all termination dates as the last day of the month.

Q: How do I terminate my group health plan?

A: You may terminate your group coverage by submitting a request in writing to your account manager, including your reason for termination and the requested effective date. Termination requests cannot be processed retroactively and must be submitted in advance.

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SECTION 4

ACCOUNT.KP.ORG

Account.kp.org is our 24-hour web-based account management system. It allows you to:

- Manage members by enrolling, terminating, and updating group membership.
- Manage payments by making one-time payments, setting up or managing recurring payments, and viewing payment history and transaction details.
- View and print premium payment invoices.
- Order ID cards.
- Manage email notification preferences for e-receipt and bill notifications.
- View group documents.

Note: If you have an active broker/producer of record, they will have the same online membership capabilities as you do for enrolling and maintaining membership. As a reminder, the primary group administrator for your account can always manage account access.

REGISTERING FOR ACCOUNT.KP.ORG

See the "Sign Up" section on page 23 for step-by-step instructions.

FREQUENTLY ASKED QUESTIONS — ACCOUNT.KP.ORG

Q: How does online bill payment work?

A: After you sign up to use account.kp.org, sign in and select "Manage Payments." Here, you can make one-time payments, set up and manage recurring payments, and sign up and manage email notifications.

Q: Are enrollment changes immediate?

A: Enrollment and coverage changes are completed immediately in accordance with their applicable effective or cancel date. Changes are registered on our system when you click on the "Submit" button. If the online system cannot match the enrollee to an existing record with 100% accuracy, the information is sent to an account administration representative for manual processing. Our service goal is to process manual enrollments within 8 business days.

Q: When can I begin using account.kp.org?

A: After you have submitted the User ID Request Form, we will email you your access code to complete registration. Once you enter your user ID and password, you can begin using online services. You can also call to obtain your user ID and password within 3 business days of submission at **1-866-575-3562**.

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Q: Can I create an additional user ID for another person?

A: Yes. We provide you with one user ID that gives you administrator privileges. That ID allows you to create additional user IDs for individuals you want to have access to the site. You can also vary their privileges according to their responsibilities. (This function is under the "Account Access" dropdown menu on account.kp.org.)

Q: I am the new billing contact (administrator) for the group. Can I use the user ID and password of the previous administrator?

A: No. Your account manager must first receive official notification and process the contact change.

Go to account.kp.org/broker-employer/resources/employer/floating/requestuserid to change your primary administrator.

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SECTION 5

SENIOR ADVANTAGE (MEDICARE ELIGIBILITY)

Your commitment to high-quality health care for your employees doesn't have to end when they become Medicare eligible. You can offer your Medicare-eligible employees the same access to our physicians, services, and facilities that our other members have — and for a reasonable monthly premium.

Kaiser Permanente Senior Advantage picks up where Medicare leaves off. It combines Original Medicare coverage and Kaiser Permanente traditional coverage, and features unique to Senior Advantage (such as an alternative care benefit and health club benefit), into a single comprehensive plan.

MEDICARE ELIGIBILITY

Generally, seniors become eligible for Original Medicare (Parts A and B) on the first day of the month in which they turn 65. If a member turns 65 on the first day of a month, he or she is eligible on the first day of the preceding month. Some beneficiaries under age 65 become eligible for Medicare due to disability or end stage renal disease (ESRD). Those eligible due to disability are eligible 24 months after they begin receiving Social Security payments; those eligible because of ESRD become eligible shortly after diagnosis.

BREAKDOWN OF MEDICARE

Part A — Provides for inpatient services (hospital, skilled nursing facility, hospice, home health). Part A is free, as long as you or your spouse have had 40 quarters (10 years) or more of Medicare-covered employment.

Part B — Provides for outpatient services (physician services, outpatient surgery, lab, radiology, durable medical equipment, and dialysis). There is a premium associated with Medicare Part B.

Part D — Provides for outpatient prescription drugs. Medicare Part D is purchased from private insurers (such as Kaiser Permanente) or through stand-alone prescription drug plans (for example, plans sold by Wal-Mart, Walgreens, and Costco). Part D is included in our Senior Advantage plans. Those enrolled in Kaiser Permanente Senior Advantage cannot enroll in stand-alone Medicare Part D coverage.

Original Medicare does not cover everything, and in many cases there are large deductibles and coinsurance for services. Medicare Advantage plans, such as Kaiser Permanente Senior Advantage, lower the out-of-pocket costs a Medicare beneficiary might expect to pay for some of these services, and enhances the benefits of Original Medicare.

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DEFERRING MEDICARE PART B

Medicare beneficiaries who decide to defer enrollment in Medicare Part B and Medicare Part D while actively working should contact the U.S. Social Security Administration for additional information. Late enrollment penalties are applied to both Medicare Part B and Part D premiums should a Medicare beneficiary not enroll in them when required to do so.

PREMIUM BILLING

When Medicare is primary and the employee/family member enrolls in Senior Advantage, he or she receives the benefits of the Senior Advantage plan. The employer will be billed the Senior Advantage premium when Medicare is primary and the active rate when Medicare is secondary.

Members enrolled in Medicare Part B either will have the premium deducted from their Social Security check, if they are receiving one, or will receive a separate premium bill at their home from the Social Security Administration.

NOTIFICATION TO MEMBERS

Unless otherwise arranged by group, approximately 3 months prior to a member's 65th birthday, KFHPNW will mail the member an enrollment kit.

SUBMITTING SENIOR ADVANTAGE ENROLLMENT FORMS

If an employee or family member is already enrolled in your group plan, he or she will need to complete only the Senior Advantage Enrollment Form. Once complete, the form can be faxed to **1-866-551-9598.*** The form must be received before the month of the member's 65th birthday. We recommended submitting the form 3 or 4 weeks before the member's eligibility date.

CANCELING COVERAGE

The Centers for Medicare & Medicaid Services (CMS) requires that members in Medicare group (Senior Advantage) plans receive written notice before termination by their group. To comply with this regulation, members in these plans may no longer be terminated retroactively. Members must receive prospective notice of the effective date of termination.

Kaiser Permanente policy requires employer groups to provide notice 30 days before terminating Medicare members. This ensures that we can process and mail the termination notice to the member within the required period. See your *Group Agreement* for information and an example.

The premiums for Medicare Advantage plans vary based on a variety of factors, including the benefits the plan offers.

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*Please retain the fax confirmation sheet as proof of submission.

MEDICARE IS PRIMARY FOR:

- **Members covered by employers with fewer than 20 employees.**
- **Members with end stage renal disease (ESRD) — when member is outside 30-month coordination period.**
- **Disabled members — when employer has fewer than 100 employees.**
- **Domestic partners who are age 65.**

When Medicare is primary, actively working employees and/or their family members may choose to defer Medicare Part B until retirement and remain on the employer's active coverage. **Members should contact the Social Security Administration to defer Medicare Part B and ensure that no late penalties will apply when they enroll at the later date.**

Members will often find the group Senior Advantage plan a positive change, as it often has richer benefits than the active group plan.

MEDICARE IS SECONDARY FOR:

- **Employers with 20 to 99 employees with members who are Medicare eligible due to age and covered under the group health benefit plan because of their or their spouse's actively working status.**

For employer groups with 20 to 99 employees, actively working employees and/or their family members age 65 and older can choose to defer Medicare Part B until retirement and remain on the group's active rates and benefits. On the other hand, they may prefer to purchase Medicare Part B and enroll in the employer's Senior Advantage offering, even though they are continuing to work. The employer will continue to be billed for the active (commercial) premium for those who enroll in Senior Advantage, but the employee/family member will receive the benefits of the Senior Advantage plan. In cases where the employer offers a deductible plan with larger out-of-pocket costs, it may benefit the Medicare beneficiary to enroll in the Senior Advantage (HMO) plan for the reduced out-of-pocket cost for medical services.

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SECTION 6

LOSING COVERAGE

For specifics related to continuation of coverage, please refer to kp.org/exploreoptions or the Continuation of Coverage Brochure. If you don't have this brochure, please contact your account manager.

STATE CONTINUATION COVERAGE FOR GROUPS WITH 19 OR FEWER EMPLOYEES AND GROUPS NOT SUBJECT TO COBRA

State continuation coverage is available according to the rules and regulations required by Oregon and Washington state law.

OREGON GROUPS

Qualified beneficiary — The following individuals may qualify for state continuation coverage after a qualifying event triggers loss of group membership:

- A subscriber covered by an Oregon group policy on the day before a qualifying event and during the 3-month period ending on the date of the qualifying event.
- A spouse or dependent child of a subscriber who, on the day before the qualifying event, was covered under the subscriber's Oregon group plan.
- A child born to or adopted by a subscriber during the subscriber's period of Oregon state continuation coverage if the child would have been insured under the subscriber's policy had he or she been born or adopted on the day before the qualifying event.

Qualifying events — Entitlement to state continuation coverage occurs when loss of membership under an Oregon group plan is triggered by:

- A subscriber's voluntary or involuntary termination of employment.
- Reduction in hours worked by the subscriber.
- Loss of dependent child status under the subscriber's policy.
- Death of the subscriber.

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Maximum length of coverage — State continuation coverage described in this section ends on the earliest of the following:

- 9 months after the date of the qualifying event.
- The end of the period for which we receive timely premium payment.
- When the member is eligible for Medicare.
- When the member is eligible for coverage for hospital or medical expenses under any other program that was not covering the individual on the day before the qualifying event.
- When the group policy ends and is not replaced with a similar plan.

Requesting state continuation coverage — To elect state continuation coverage, qualified individuals must submit a State Continuation Election Form to us or the employer within 10 days after the later of the date of the qualifying event or the date we provide notice of their right to state continuation coverage.

Monthly premium — Eligible employees and/or family members are required to pay 100% of the group premium rate to the group on a monthly basis and in advance. The group remits payment to KFHPNW.

Continuation of coverage is not available for:

- A person who is eligible for Medicare.
- Someone eligible for coverage under another group health plan that was not covering the individual on the day before the qualifying event.

WASHINGTON GROUPS

Qualified beneficiary — A subscriber and his or her covered family members if the subscriber experiences a qualifying event and he or she was covered continuously during the 6-month period ending on the date of employment termination or membership in the organization through which group coverage was provided.

Qualifying event — Loss of membership under a Washington group plan triggered by a subscriber's voluntary or involuntary termination of employment or membership in the organization through which the group coverage was provided.

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Maximum length of coverage — State continuation coverage described in this section ends on the earliest of the following:

- 6 months after the date of the qualifying event.
- The end of the period for which we receive timely premium payment.
- When the member becomes eligible for Medicare.
- When the group policy terminates.

Requesting state continuation coverage — To elect state continuation coverage, qualified individuals must submit a State Continuation Election Form to us or the employer within 31 days after the date of the qualifying event.

Monthly premium — Eligible employees are required to pay 100% of the applicable premium to the group on a monthly basis and in advance. The first premium payment must be paid within 31 days after the date on which coverage would otherwise end. The group remits payment to KFHPNW.

COBRA

The information in this section is meant as a brief informational summary and is not intended as legal advice. If this information differs from applicable law, the law prevails. Should you have any questions specific to your situation or need more detailed information, we suggest you consult your legal counsel.

WHAT IS COBRA?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal mandate for companies that offer their employees health care coverage and that employed at least 20 workers (both full time and part time) during 50% of their business days during the preceding calendar year. COBRA requires these employers to permit continued group coverage, at the enrollees' expense and for clearly specified periods, for most employees and covered family members who lose their group coverage.

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ROLES AND ADMINISTRATION

"Plan administrator," as defined by the Employee Retirement Income Security Act (ERISA), is always the employer or a third-party administrator appointed by the employer. KFHPNW has not agreed to be the plan administrator for any employer. KFHPNW is, however, the plan fiduciary (as defined by ERISA) for health care coverage for those ERISA plan beneficiaries enrolled as KFHPNW members.

We provide a separate subgroup and bill group for COBRA participants. All membership processing — such as enrollments, family account changes, and terminations — are submitted in the same manner as for your other membership changes. Please contact your account manager for subgroup and bill group information.

You are responsible for notifying employees about COBRA, including information regarding new rates or benefit changes. Members who call us for COBRA information will be referred back to their employers. We will honor enrollment based on the minimum periods as specified by COBRA rules and regulations.

A COBRA account is attached to the active contract. If the contract for the active account is canceled, the COBRA unit is canceled as well. Terminated COBRA participants may be offered the opportunity to convert to one of our individual plans at that time.

ENROLLMENT

When an employee or family member elects continuation of group coverage, he or she must complete a Group Employee Enrollment/Change Form and indicate the COBRA subgroup and bill group. You can then submit the form and report the termination the way you normally report membership changes. To be valid, COBRA enrollment must occur within a specific period following loss of group coverage.

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BILLING

You bill and collect dues from your COBRA participants. Your responsibilities include but are not limited to:

- Employee notification of COBRA availability, rates, open enrollment periods, and benefit changes.
- Collection of premium from COBRA participants.
- Remittance of premium to KFHPNW.
- Termination of COBRA enrollment, per mandate. (We will bill and collect for your COBRA enrollment and bill groups the same way we bill and collect for all your other enrollment and bill groups.)

The first COBRA premium payment must be retroactive to the member's termination from active status and must be received within the allowable period. All subsequent premium payments are due on or before the first day of the coverage month and are allowed a grace period not to exceed 30 days.

WHEN COBRA BENEFITS END

Members who do not pay their COBRA premiums can be canceled from your plan after 30 days. You will be responsible for removing COBRA members from the plan once they have exhausted their COBRA benefits. Both are accomplished by submitting a member cancellation form.

COVERAGE DURING ELECTION PERIOD

Members who intend to elect and pay for COBRA coverage may use our services during the interim between their termination from the parent account and their reinstatement as COBRA participants. You should make them aware of the following:

- It is advisable (but not mandatory) that the qualified beneficiary retain a copy of the COBRA enrollment form to use as a temporary ID.
- If the qualified beneficiary uses services but does not elect to pay for COBRA coverage within the specified period, KFHPNW will bill the individual as a nonmember for all services received.

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OPEN ENROLLMENT

If you offer your active employees the opportunity to change their health coverage during an open enrollment period, then you must offer the same opportunity to your COBRA participants. 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).

HELPFUL TOOLS

If you would like more information about COBRA, please contact one of the following:

- U.S. Department of Labor
  www.dol.gov
- Employee Benefits Institute of America
  206-546-6810
  www.ebia.com
- Infinisource, Inc.
  1-800-300-3838
  www.infinisource.com

INDIVIDUAL AND FAMILY PLANS

We offer individual coverage through Kaiser Permanente for Individuals and Families (KPIF). These plans feature a range of coverage and prices.

For Oregon and Washington residents, open enrollment runs from November 1 through January 15. For coverage effective January 1, we must receive your completed application by December 15 — otherwise, your effective date will be February 1.

You may enroll outside of open enrollment if you have a special enrollment period qualifying event, such as an involuntarily loss of group coverage. To learn more about transitioning to new coverage, visit **kp.org/continuecoverage** or call **1-800-603-3743** to speak with a transition specialist. To look at individual plan options, visit **buykp.org**.

PPO Plus® members losing group coverage have unique plan options. To get plan and enrollment information, please contact Member Services at **1-866-616-0047.**

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SECTION 7

MANAGING YOUR HEALTH CARE PLAN AT RENEWAL

RENEWAL PACKET

Every year, you will receive a renewal packet providing you the opportunity to make changes to your coverage. If you have a broker/producer, he or she will receive the renewal packet to pass along to you. This is done primarily through email.

The renewal packet contains your new plan rates, a list of your current and renewing benefits, medical plan and dental plan benefit details, rating and underwriting assumptions, plan updates, and an Employer Application.

RENEWAL DECISION

You can make changes anytime up to the 15th day of the month before your renewal effective date. Returning the Renewal Decision Form 30 days in advance of your renewal allows us time to update our systems earlier so that changes will appear in your invoice sooner.

Even if you are not making changes, please submit your completed Renewal Decision Form to small.group.respond@kp.org.

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OPEN ENROLLMENT

Open enrollment is the month preceding your renewal effective date. During open enrollment, eligible employees and their eligible family members who did not enroll when they initially became eligible may enroll. Additionally, members who are already enrolled may make plan changes during open enrollment. These employees must complete and sign a Group Employee Enrollment/Change Form at the time of the open enrollment period. Delaying this process may prevent enrollment. Enrollment is not needed for employees or their family members who are currently enrolled in your plan.

If you offer a bundled medical plan (2 or 3 plan choices), employees may indicate their plan selection on the 2-in-1 Employee Benefit Designation Form or the 3-in-1 Employee Benefit Designation Form. If employees are enrolled in a bundled plan that is not changing, they do not need to sign a form each year.

UNDERSTANDING RATE CHANGES

A number of variables affect the rate you pay for health coverage. We have gathered some of these factors below with brief explanations to keep you well-informed.

PLAN SELECTION

Rates are based on each plan's specific combination of benefits. Your rate depends on the plan(s) you choose.

RATE DETERMINATION

Your group premiums depend on several rating factors, including the number of members in your group, demographics (the ages of covered employees), and family content (the number of people in a family). If you have added or deleted employees or family members since last year's renewal, your rate may be affected by those changes.

HOW TO LOWER YOUR HEALTH CARE COSTS

While a rate increase may be necessary for us to continue providing your group with quality care, we realize that higher health expenditures may also make it more difficult for you to continue providing coverage for your employees.

You may be able to offset your rate increase by switching to a different plan or plans. For example, choosing a plan with a deductible or a higher office visit copayment could lower your premiums. To decide which plan is best for your group, please contact your broker/producer or account manager.

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EMPLOYER CONTRIBUTION AND PAYROLL DEDUCTIONS

Another way to lower your costs is by reducing your contribution and increasing your employees' payroll deductions. The minimum employer contribution for coverage is 50% of the employee-only rate. Beyond the minimum employer contribution, any part of your company's health coverage costs not paid by your company must be collected from your employees through payroll deductions. Note that increasing the amount of the premium your employees are accountable for could decrease enrollment in your plan and affect your rate though a shift in your group demographic.

WHEN CHANGES APPEAR ON YOUR INVOICE

Coverage with us is prepaid, so your monthly invoice covers the following month. For example, the bill you receive in May is for June's premium. So, any changes processed after the time we issue your bill (around the 10th of each month) will appear on the following month's bill.

If your benefit or enrollment changes at renewal affect the month for which you have already been billed, we will adjust your account. Any adjustments are shown on the "Retroactive Dues and Charges" section of your next statement.

Note: If your new premium is not reflected on your renewal month's invoice, you can pay as billed. On the following billing statement, we will correct the amount owed back to your renewal date. If there is any overpayment on your account, it will appear as a credit on the next month's bill. If a balance is owed, it will also appear on the next month's bill.

FREQUENTLY ASKED QUESTIONS — MANAGING YOUR HEALTH CARE PLAN AT RENEWAL

CHANGING YOUR BENEFITS

Q: When can I make changes to my coverage?

A: You can make changes to your coverage once a year on your renewal date. If you are considering making a change to your coverage, contact your broker/producer or account management team at **503-813-2630** (option 3). He or she will be happy to guide you through the process and offer options based on your specific situation and needs.

Q: How do I keep my plan at renewal?

A: Your current plan may or may not be available at the renewal date. If your exact plan is no longer available, a near match will be offered for your renewal. If you need additional enrollment kits for your employees, contact your account management team at **503-813-2630** (option 3). Enrollment materials are also available on our website **account.kp.org**.

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Q: When should I inform you about a change in coverage?

A: Contact your broker/producer or account manager as soon as you know you are going to change coverage. Letting us know right away is the key to making sure your account is updated as quickly as possible. Change requests must be communicated using the Renewal Decision Form.

DENTAL

Q: How do I add dental coverage?

A: Dental coverage can be added on the first of any upcoming month during your 12-month medical contract. If your group adds dental coverage, it must be made available to all your covered subscribers and family members. You may change dental coverage only on your group's renewal date.

Contact your broker/producer or account manager for available plans.

When adding dental coverage at renewal, make your selections on the Renewal Decision Form. To add dental coverage at a time other than your renewal date, complete the Small Group Dental Enrollment Application. Each enrolling employee must also complete a Group Employee Enrollment/Change Form. For a complete list of guidelines, see our Rating and Underwriting Assumptions document.

BILLING AT RENEWAL

Q: How long does it take to update the billing records after a change in coverage?

A: Bills are generated around the 10th day of each month. Changes made after that date are not reflected until a following statement. If you have questions about billing, please review your account online at account.kp.org.

Q: Am I responsible for paying my bill even if it doesn't reflect my change in coverage?

A: Yes. You should pay as billed. Later bills will show any adjustments due to changes in coverage. You may also adjust your bill to your new amount. Any calculation errors from your adjustments will be reflected in later bills.

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SECTION 8

PRIVACY PRACTICES

Kaiser Permanente is committed to protecting the privacy of all members' personal health information. All of our health care providers and staff must comply with this policy, whether they are communicating in oral, written, or electronic form.

We refer to a member's personal health information as protected health information, or PHI, because of the Health Insurance Portability and Accountability Act (HIPAA). This information, whether oral, written, or electronic, includes the member's name, Social Security number, and any other information that identifies the member. Members generally may see and receive copies of their PHI. They may correct or update the information. They also may ask for an accounting of certain disclosures of their PHI.

Members have the right to approve or deny the release of their PHI in most situations. However, we may use or disclose their health information for treatment, payment, and health care operations, or as otherwise permitted by law. Health care operations include health research and measuring the quality of care and services. We sometimes are required by law to give PHI to government agencies or courts of law.

DISCLOSURES TO A MEMBER'S EMPLOYER OR EMPLOYEE ORGANIZATION

If a person is a Kaiser Permanente member through his or her employer or employee organization, we may share certain PHI with them without the member's authorization — but only when permitted by law. For example, we may disclose the member's PHI for a workers' compensation claim or to find out if the member is enrolled in the plan or if premiums have been paid on the member's behalf. For other purposes, such as inquiries by the member's employer or employee organization, we will obtain the member's authorization to release information.

We will not use or disclose a member's PHI for any other purpose without his or her (or the member's representative's) written permission, except as described in our *Notice of Privacy Practices*. If a member thinks his or her PHI was shared without prior permission in a way not authorized by law, the member should call Member Relations at **503-813-4480** from the Portland area or **1-800-813-2000** from all other areas (ask for Member Relations).

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ACCESS TO PHI

In most cases, a member or the member's legal guardian or personal representative may see or obtain copies of the member's PHI. If the member is unable to make health care decisions on his or her own, someone the member names may be able to request his or her records. If the member thinks part of his or her medical record is incorrect, the member may ask to add a statement to amend the record.

In some cases, a member's access to his or her PHI is restricted by law or because it would be detrimental to the member's well-being.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describes all of these practices in detail. For more information or to request a copy, please call Member Services. You can also find the *Notice of Privacy Practices* in your *Evidence of Coverage (EOC)* booklet (**kp.org/eoc**).

RELEASE OF INFORMATION

The following information will help guide you and your employees on how to request or release medical records, receive work-related leave authorization, and manage care and treatment for a member or their loved one.

Requests to the Release of Information Department:

We accept email, mail, and fax submissions. In all correspondence, please include the name, date of birth, and medical record number of the person who received care.

Website: **kp.org/releaseofinformation**

Email: **nw.roi@kp.org**

Phone: **503-571-5051** or **1-800-813-2000** (Monday through Friday, 8 a.m. to 4:30 p.m. Pacific time)

Fax: **503-571-2624**

Mail:

Release of Information
Kaiser Permanente HIM
10220 SE Sunnyside Rd.
Clackamas, OR 97015

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Locations:

Regional Process Center — Release of Information
10220 SE Sunnyside Rd.
Clackamas, OR 97015
Monday through Friday, 8 a.m. to 5 p.m. Pacific time

Longview-Kelso Medical Office
1230 Seventh Ave.
Longview, WA 98632
Monday through Friday, 8 a.m. to 4:30 p.m. Pacific time

North Lancaster Medical Office
2400 Lancaster Dr. NE
Salem, OR 97305
Monday through Friday, 8 a.m. to 5 p.m. Pacific time

Requests to your clinical team:

Email your clinical team via **kp.org** for further instructions. You may also find your team's phone number by calling **1-800-813-2000** or via **kp.org**.

Still not sure who to contact with your questions? Email or call the Release of Information Department using the contact information above, and we would be happy to help you.

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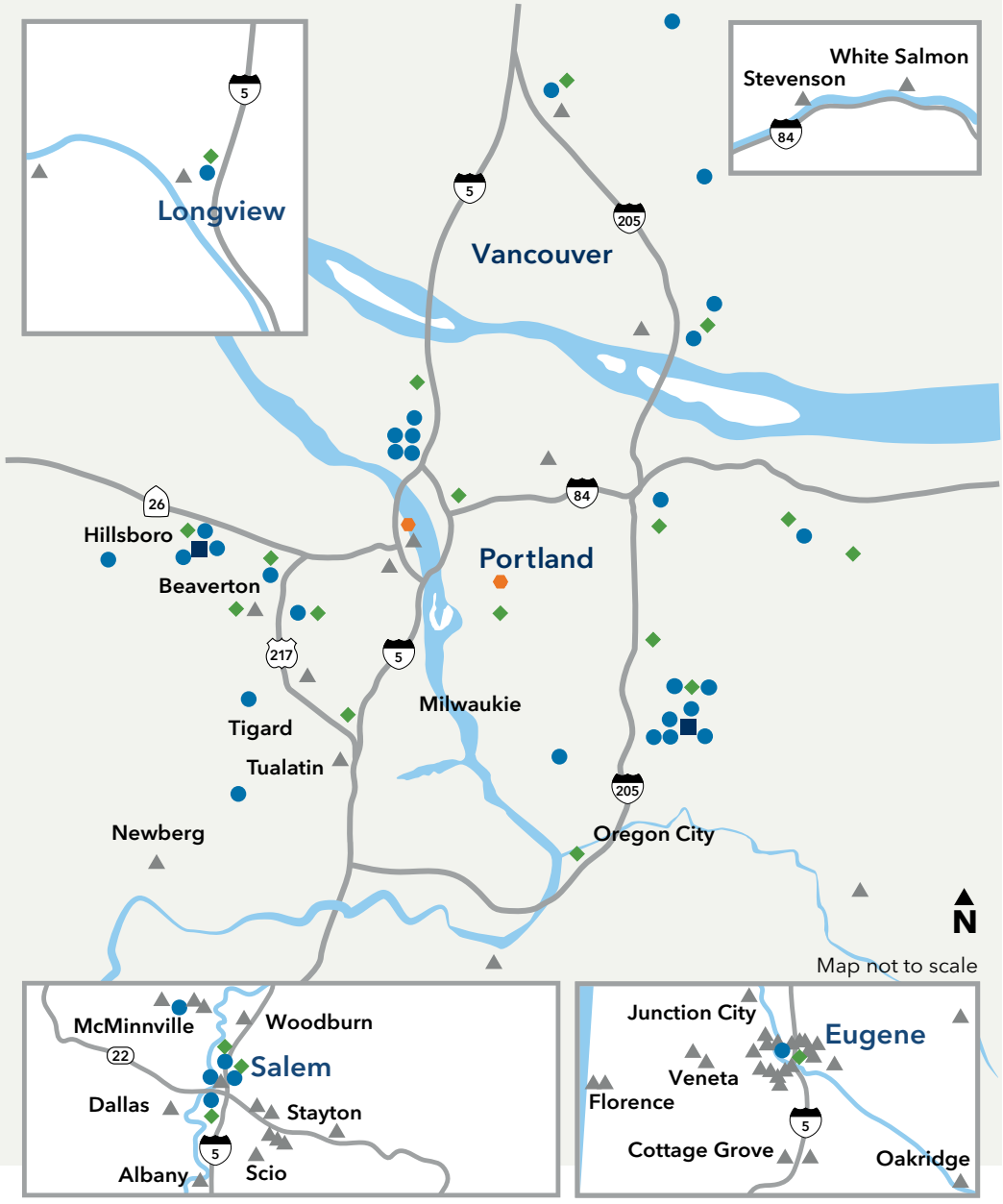
SECTION 9

SERVICE AREA MAP AND LOCATIONS



Facility information current as of December 2022.

Go to kp.org/locations to see all our current locations and to find the facility closest to you. Or call Member Services at **1-800-813-2000** (TTY **711**).

WHERE TO FIND CARE
OREGON AND SOUTHWEST WASHINGTON

Dental

With Kaiser Permanente's coordinated medical and dental care and coverage, it can be simpler to take care of your total health. Our skilled dentists, convenient dental locations, and quality services will make you smile. Learn more at kp.org/dental/nw.

Pharmacy

Most of our Kaiser Permanente medical offices include pharmacy services. You also have the option of using our mail-order pharmacy service to fill and refill most prescriptions.

visionessentials by KAISER PERMANENTE®

Our optometrists, ophthalmologists, and opticians work together within our integrated care delivery system and are able to connect to our larger team of medical professionals and services.

Learn more at kp2020.org/pacnw.

careessentials® by KAISER PERMANENTE®

Care Essentials by Kaiser Permanente are convenient care clinics that provide nonemergency and preventive health services to both Kaiser Permanente members and nonmembers.

- Treatment for minor illnesses and injuries
- Preventive services, including checkups, vaccinations, and some lab and diagnostic testing

Learn more at careessentials.org.

Affiliate Providers

Kaiser Permanente health plans include access to affiliate providers for primary and specialty care, including The Portland Clinic.*

*Not available as an in-network provider to members on Medicaid, receiving full Medical Financial Assistance from Kaiser Permanente, or visiting from another Kaiser Permanente region.

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SECTION 10

GLOSSARY

Account
Consists of a subscriber and all the eligible enrolled family family members.

Account manager
The Kaiser Permanente representative who is responsible for the ongoing management of existing employer accounts.

Bill group
A 2-letter combination used in conjunction with the group number to identify the group's membership payment allocations.

Broker/producer
A third party who is either an individual or company and sells KFHPNW health plans. The broker/producer usually receives a commission associated with the sale and service of an account and acts as the contact for the employer.

CMS
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that applies to employees (and their covered family members) of most employers of 20 or more employees. COBRA allows certain former employees and their family members to continue their group coverage temporarily by paying the group for their monthly dues. If requested by the group, we can bill their members for COBRA; however, COBRA administration is always the responsibility of the employer group.

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. Coverage usually becomes effective on the first day of the month.

Dependent (family member)
A member whose relationship to a subscriber is the basis for membership eligibility and who meets the eligibility requirements as a dependent. A dependent can be a spouse, domestic partner, or child.

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Disabled dependent
A subscriber's or spouse's dependent who exceeds the age limit for family members **may be** eligible for coverage if all of the following requirements are met:

- Dependent is incapable of self-sustaining employment because of developmental disability, mental illness, or physical disability that occurred prior to reaching the age limit for family members set forth in the *Group Agreement.*
- Dependent receives a substantial amount of his or her financial support and maintenance from subscriber or subscriber's spouse.

Discrepancy
The difference between the amount due from an employer and the amount paid.

Electronic File Integration (EFI)
Electronic File Integration (EFI) is an electronic processing method that automates the management of membership data. Employer groups and Third Party Administrators (TPAs) using EFI can submit family and member information to Kaiser Permanente using an electronic medium.

Event date
The event date is the date of a qualifying event that resulted either in the enrollment of an employee or in the addition or deletion of a family member. Events can include birth of a child, marriage, new hire, adoption, and so on.

Evidence of Coverage (EOC)
Each *EOC* document that is included in the *Group Agreement* contains information about benefits, coverage, and other contractual provisions that are pertinent to both the member and the employer.

Group Agreement
The contract between KFHPNW and the employer. The *Group Agreement* includes the *Evidence of Coverage (EOC),* Benefit Summary, and amendments.

Group/employer
An employer, organization, union trust, or association that has a *Group Agreement* with KFHPNW for health care benefits.

Group number
A unique 5-digit number assigned to an employer group as a means to identify contract, benefits rates, and billing information.

Medical record number
A unique lifetime number issued by KFHPNW to each patient and/or member. Medical records are accumulated and maintained, and patient and member information is maintained under this number.

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Medicare
A federally funded national health insurance program administered by CMS to provide medical care to individuals 65 and older, certain younger disabled people, and people with end stage renal disease (ESRD). Medicare is divided into 3 parts: hospital insurance (Part A), medical insurance (Part B), and prescription drug insurance (Part D).

Member
A person who is an eligible and enrolled employee, retiree, or family member under a *Group Agreement* and for whom we have received an applicable premium.

Member ID card
Identification card that shows the member's medical record number used to identify medical records and membership information.

Membership
The enrollment of a subscriber and/or family members within an employer enrollment unit. Membership is a contractual agreement with a purchaser, a subscriber, and KFHPNW.

Open enrollment
The period, usually annual, during which employees and their covered family members can choose to make changes among any health plans offered by their employer, and the opportunity for the employee to add family members to or delete family members from their coverage without a qualifying event.

Overage dependent
A dependent who is older than the maximum age limit for general or student dependent eligibility as defined under the *Group Agreement.*

Plan documents
Documents that detail the coverage purchased by groups and the eligibility rules, policies, and regulations that define the provisions under which KFHPNW agrees to provide health care coverage. This also includes the *Evidence of Coverage (EOC)* booklet mailed directly to subscribers from KFHPNW on an annual basis.

Premium due date
Date by which premiums are expected by Kaiser Permanente.

Probationary period
The probationary period is the length of time a new employee must wait before becoming eligible for health coverage on the first of the following month. The employer selects its probationary period when enrolling its group. To comply with the Affordable Care Act, all employer groups must ensure that they do not impose any waiting period in excess of 90 days on their employees for enrollment on their medical plans.

Qualifying event
An event such as marriage, birth, divorce, or loss of coverage that allows an individual to make an election change, add family members to, or delete family members from their health plan coverage.

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

Renewal
An annual offering to eligible groups to renew for a 12-month period. Employer premium rates and benefits are subject to change at this time. Employers may also change plan selection(s), eligibility, probationary periods, contributions, and hourly requirements. This is also the period of open enrollment.

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

Schedule A (Form 5500)
A document Kaiser Permanente provides that outlines group plan payments and refund information for a specific period. Employers often use this to submit benefit plan information to the Internal Revenue Service each year.

Service area
Geographic area in which a person must live or work to enroll as a KFHPNW member, as designated by ZIP code or county.

State continuation
Coverage that allows employees and their family members to continue group medical insurance even after employment, membership, or marriage has ended. State continuation coverage is available to groups with fewer than 20 employees. These groups are not eligible for COBRA coverage.

Subgroup
A subset of a group number that is a 3-digit combination used to signify a particular plan or contract that the group offers to its employees.

Subscriber
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 set forth under the *Group Agreement*.

Termination
The end of a member's health care coverage (enrollment) through KFHPNW. Membership is terminated when requested by the group or member and for nonpayment of premium, fraud, or loss of employer coverage. This term is also used to describe the end of a health plan contract for an employer group. Termination can occur at any time, and therefore does not require a qualifying event. The termination date is the last day with coverage. Keep in mind that it may impact a flexible spending account.

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SECTION 11

FORMS

Use the following forms to request changes to your account. You can download and print some of these forms through our website at account.kp.org. Alternatively, you can call your account management team at **503-813-2630** (option 3) to request more.

2-in-1 Employee Benefit Designation Form: Use this form when offering 2 of our medical or 2 of our dental plans to your employees to inform us of their plan selection.

3-in-1 Employee Benefit Designation Form: Use this form when offering 3 of our medical plans to your employees to inform us of their plan selection.

Change of Ownership Form: Complete this form when company ownership is changing, and include the bill of sale.

Employer Administrative Changes Form: Use this form when updating group address and contact information.

Group Employee Enrollment/Change Form: Have employee complete this form for enrolling self and/or family members or making changes to enrollment. Group must complete the employer section. For KFHPNW, there are separate forms for Oregon and Washington depending on state where the contract is held, not by the resident location of the employee.

Member Cancellation of Coverage Form: Complete this form when canceling employees and/or their family member(s).

Renewal Decision Form: Employer form for small group employers to provide selected plan choices to renew their coverage with Kaiser Permanente.

Small Group Dental Enrollment Application: Employer form for small group employers to add dental coverage when your group already offers a small group medical plan with KFHPNW.

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