COLORADO

2024
Group Administrator's Manual

KAISER PERMANENTE®

Table of contents

Introduction

Thank you for choosing Kaiser Permanente for your health care and coverage. We appreciate the opportunity to provide affordable, quality care and coverage for you and your fellow employees. We hope that by helping you thrive, we're helping your business thrive, too.

This Manual is designed to answer many of your questions, as well as help you understand how your contract with Kaiser Permanente is administered. We encourage you to keep it handy and refer to it as questions arise. As you'll see, this document does not address specific products.

Important contact information

Please keep the contact information below at your fingertips and refer to it when you have a question – there are a variety of resources just a call or a click away.

Note: For any Kaiser Permanente telephone number(s) that do not have a TTY number (for the deaf and hard of hearing) listed, please call Relay Colorado at 711 when using TTY equipment.

Contact		For questions about	Hours (MT)
Membership Administration Department **1-866-868-7220**	**Email** **csc-den-roc-group@kp.org** **Fax** **1-866-311-5974** **Kaiser Permanente Membership Administration** P.O. Box 203004 Denver, CO 80220-9004	• Enrollment activities (e.g., additions, cancellations, etc.) • Invoices and billing • Payment of monthly premiums • Membership reconciliation • Accounts receivable • Member ID cards • Medicare enrollment	Monday–Friday: 7 a.m. to 7 p.m.
Sales and Account Management **Large Group –** contact your account executive	**Small Group** **1-866-331-2091** (TTY **711**) **Kaiser Permanente Sales Department** 10350 E. Dakota Avenue Denver, CO 80247	• Quoting assistance • Renewal questions • Open enrollment planning • Brochures and forms • Enrollment procedures	Monday–Friday: 8 a.m. to 5 p.m.
Employer Broker Services (EBS) **303-344-7241**, or **1-866-710-2727** (TTY **711**)	**Email** **CO.KP.EBS@kp.org** **Fax** **303-306-2549**	• Benefit interpretation • Eligibility issues • Employer-level claims resolution • Facility and physician locations • Legal and regulatory issues • Enrollment/process	Monday–Friday: 8 a.m. to 5 p.m.
Member Services Contact Center	**303-338-3800** or **1-800-632-9700** (TTY **711**)	• Benefit clarification • Filing a complaint • Selecting a personal physician • New Member meeting schedule • Obtaining claim forms • Individual and family plan enrollment forms • Address changes	Monday–Friday: 8 a.m. to 6 p.m.

Important contact information *(continued)*

Contact		For questions about	Hours (MT)
Claims Department **303-338-3600 or 1-800-632-9700** (TTY **711**)	**Kaiser Permanente Claims Department** P.O. Box 373150 Denver, CO 80237-3150	• Status of filed claims	Monday–Friday: 8 a.m. to 6 p.m.
Telephone Medicine Center/Quality Resource Coordinator	**1-877-895-2705**	• Notification about Members who have been admitted to an out-of-plan hospital (contact us within 24 hours)	Monday–Friday: 8 a.m. to 6 p.m.
Patient Financial Services	**303-743-5900, or 800-632-9700** (TTY **711**)	• Accounts receivable • Other insurance billing • Third-party liability • Coordination of benefits	
Away from Home Travel Line	**951-268-3900**	• How Members can access and receive care while outside our service areas (please also refer to the Member's *Evidence of Coverage*). **Benefits include:** • Visiting Member Services • Out-of-Area Benefit • Emergency and urgent care	24 hours per day

Glossary of terms

Affiliated Plan Providers
Affiliated plan providers belong to a local medical group with whom we have contracted to provide care to Kaiser Permanente members. The availability of affiliated plan providers may change during the year.

Bill Group or Billing Unit
An account created for billing purposes. A Group can choose to have multiple bill groups/billing units if multiple invoices or bills are needed.

CPMG
Colorado Permanente Medical Group (CPMG) is an independent, multispecialty group of physicians that provides covered medical/health care services to members in the Colorado service areas.

Colorado Uniform Employee Application for Small Group Health Benefit Plans (CUE App)
A state-mandated application and change form for small-group employees. Spanish-language version available as well.

Dependent
A spouse, child, or other eligible person receiving coverage under a Subscriber's account.

Family
Unit consisting of a Subscriber and any eligible Dependents.

Group
Business or organization that has contracted with Kaiser Permanente to provide health care to its employees.

Group Enrollment/Change Form (Enrollment/Change Form)
The Kaiser Permanente application and change form for large Group health plans is available in both English and Spanish.

Health Record Number (HRN)
Individual number assigned to each Member and featured prominently on their Kaiser Permanente ID card. This is also sometimes referred to as their medical record number, or Member identification (ID) number.

Invoice
Monthly bill or statement produced to detail health care premiums.

Member
Individual receiving health care coverage from Kaiser Permanente. This person can be a Subscriber or a Dependent.

Service Area
Kaiser Permanente's service area includes 17 Front Range counties listed in the Definitions section of the *Evidence of Coverage*.

Subgroup
An account created to track a Group's contract. If there's more than one program carrier, the Group is assigned multiple subgroups.

Subscriber
Policyholder of the family, usually an employee of a Group.

About Kaiser Permanente

Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We currently serve more than 12 million members in 8 states and the District of Columbia.

Founded in 1945, our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. Care for members and patients is focused on their total health and guided by their personal physicians, specialists, and teams of caregivers. Our world-class medical teams are supported by industry-leading technology and tools for health promotion, disease prevention, care delivery, and chronic disease management.

How we deliver care

Kaiser Permanente provides direct care to members through an integrated delivery system. Unlike insurance that just pays medical expenses, we provide or arrange for medical and preventive services in Kaiser Permanente medical offices and contracted hospitals.

Kaiser Permanente Colorado is a partnership between the Health Plan (which develops and administers various types of health care plans) and the Colorado Permanente Medical Group (CPMG), an independent, multispecialty group of physicians.

CPMG physicians work together in a multisite group practice, drawing upon each other's professional expertise and specialty training to prevent disease and treat illness. Medical care is provided by CPMG physicians, nurse practitioners, physician assistants, and other skilled medical professionals, working as coordinated teams.

Kaiser Permanente also has a collaborative care model that combines the community network and integration. In addition to a large network of Affiliated Providers, Members can also access medical services at any one of our medical offices along the Front Range. Visit **kp.org/locations** to find a list of our medical office locations.

Out-of-area dependent coverage

The Out-of-Area Benefit* applies to eligible Dependents up to age 26 (including spouses, partners and children) who receive care outside of the Kaiser Permanente service area.

For questions and details about this benefit, members can contact the Away from Home Travel Line (see contacts section).

*Certain exclusions, coinsurance/copayments and terms and conditions apply, as outlined in the Member's *Evidence of Coverage*. Dependents must meet plan and group eligibility requirements (as applicable). Traditional Preferred Provider Option (PPO) and Point-of-Service (POS) plans are not eligible for this benefit.

Enrollment

New employees and their dependents

New employees must enroll themselves and any eligible Dependents within 31 days after becoming eligible. Eligible employees who do not enroll themselves and their Dependents during this time period must wait until your Group's next open enrollment period to enroll.

New employees and their Dependents will be accepted for enrollment in your group's Kaiser Permanente plan(s) when:

- They meet your Group's eligibility requirements that we have approved; and
- They meet Subscriber or Dependent eligibility requirements; and
- They reside within Kaiser Permanente's service area at the time of enrollment.

Employees will be enrolled in regional plans, based on the following guidelines:

- Members must reside within the service area to be eligible to enroll in a Kaiser Permanente Health Plan.

Open enrollment

During your annual open enrollment period, all employees who did not enroll in Kaiser Permanente when initially eligible are given an opportunity to enroll themselves and their Dependents. The open enrollment period and the effective date of coverage are shown on the Face Sheet of your Group Agreement. Contact your account executive to change your Group's open enrollment period or effective date.

Effective Dates:

- **90-Day waiting period**
  A Group plan may not impose any waiting period that exceeds 90 calendar days. A "waiting period" is the time between the date an employee becomes eligible for coverage and the date the employee's coverage becomes effective. A waiting period does not begin until the employee has satisfied the plan's eligibility requirement. Groups are required to maintain all back-up enrollment records to supply Kaiser Permanente with, in the event of a Colorado Division of Insurance (DOI) audit request.
- **How does a merger or acquisition affect the 90-day waiting period?**
  Employees already enrolled in the health plan for the company being acquired may be enrolled without completing the Group's initial waiting period. Those who haven't completed the initial waiting period will still need to do so, before their coverage can take effect.
- **Non-plan hospital admission policy**
  A person who is hospitalized in a non-plan hospital on his/her effective date of coverage will not receive benefits (except for covered emergency care) until a Kaiser Permanente physician becomes involved in or directs the patient's care, or the patient is transferred to a designated Kaiser Permanente hospital. This policy includes newborns. To report a non-plan hospital admission, call the Quality Resource coordinator.

Enrollment *(continued)*

Employees who live outside the service area

All small group Members and large group Members (that have been approved) must live or work within the Kaiser Permanente of Colorado service area to be eligible to enroll in the Health Plan. Large Groups must request and be approved for the live or work provision by sales department management.

Large Groups may request an exception to the rule that Subscribers may not enroll if they reside within the service area. Such requests must be reviewed and approved by sales department management.

Members who move outside the Colorado service area subsequent to enrollment are allowed to retain their membership. However, because coverage in this situation will be limited, they will receive an "Out-of-Area" letter that explains these limitations.

Members who move to another Kaiser Permanente Health Plan service area may be able to transfer their Group membership, if there is an arrangement with your Group in the new service area.

Exception

If a Kaiser Permanente Senior Advantage Member takes an extended trip or resides outside of their Medicare-approved service area for more than 6 months in a row, their membership with Kaiser Permanente must be canceled.

Dependents

Under Colorado law, Dependents are defined as:

- Your spouse, including a same-sex spouse, your partner in marriage or a civil union as determined by Colorado law
- Your or your spouse's children (including adopted children, children placed with you for adoption, and, in the case of small groups, foster children*) who are under age 26.

Other persons (not including foster children) are considered Dependents if they meet all of the following requirements:

A. They are under age 26; and

B. You or your spouse is the court-appointed, permanent legal guardian (or was before the person reached age 18).

You or your spouse's unmarried children who are medically certified as disabled and are dependent upon you or your spouse. Such persons are eligible to enroll, or continue coverage as your Dependents, if the following requirements are met:

A. They are dependent on you or your spouse; and

B. If requested, you need to provide proof of the Dependent's disability and dependency, annually.

Designated beneficiaries, as prescribed by Colorado law, are also eligible Dependents, if your employer elects to cover them.

*Foster children are automatically eligible for Dependent coverage if Subscriber's coverage is administered through a small group employer. Large Groups may elect to cover foster children as eligible Dependents.

Enrollment *(continued)*

1. Legally recognized partnerships

A. Common-law marriage

In Colorado, a common-law marriage is legal and valid when a man and a woman consent to live together in the same house and represent themselves to the public as husband and wife.

Common-law marriages entered into on or after September 1, 2006, are not valid unless each party is 18 years of age or older. Colorado also recognizes as valid any marriage that is legal in the state in which it was entered. However, a common-law marriage entered into outside of Colorado, on or after September 1, 2006, between two people who were not 18 years of age or older, is not recognized as valid.

A common-law spouse may be enrolled at the time of initial enrollment, or within 31 days from the date of cohabitation. In either case, an application must be received. The eligible children of a common-law spouse may be added at the same time as the common-law spouse.

B. Domestic partnership

"Domestic Partnership" describes the relationship of a couple that is not legally married but is otherwise jointly committed to a long-term relationship. Domestic partner coverage is available to same-sex and opposite-sex partners upon the Group's election. Contact your account executive for the rules.

C. Civil union

The "Civil Union Act" authorizes any two unmarried adults, regardless of sex, to enter into a civil union provided that neither party is a party in another civil union or married to another person.

Civil unions include same-sex marriages and domestic partnerships that were legally entered into in another state.

Civil-union partners are granted the same rights, privileges and responsibilities under the law as spouses, including the right to be covered as a Dependent in a health insurance policy or HMO contract.

2. Dependent children

Dependent children include natural children, stepchildren, legally adopted children, grandchildren and foster children (per restrictions outlined below) and children under "permanent" court-appointed legal guardianship. With the exception of children under legal guardianship, Dependent children do not have to reside in the household of the Subscriber.

A. Newborns

The newborn child of a Subscriber or their spouse will be automatically enrolled, and covered for the first 31 days, following birth. An Enrollment/Change Form for large Group Members or the CUE App for small Group Members must be received within the initial 31 days following birth in order for coverage to continue beyond the first 31 days.

B. Grandchildren

The newborn child of a Member's covered Dependent child (i.e., the Member's grandchild) may be eligible for coverage, depending upon your Group's plan.

Grandchildren are not automatically enrolled (as newborns are above). To obtain coverage, the Member must submit a statement indicating the Dependent child and newborn are dependent upon the Member for support, and that the Member will notify Kaiser Permanente of any change in the status of the Dependent child (e.g., financial independence, age limit, etc.).

The grandchild's eligibility for coverage terminates at the same time as the Dependent child's coverage. If the Member's Dependent child is not a Member at the time of the baby's birth, the baby is not eligible for coverage, unless the Member has obtained permanent legal guardianship.

Enrollment *(continued)*

C. Foster children

Foster children are considered eligible Dependents if the Subscriber's coverage is administered through a small Group employer, or a large Group employer has elected to cover foster children. Foster children's enrollment eligibility begins on the date the child is placed in the Subscriber's home.

D. Disabled over-age dependents

Colorado law defines a disabled Dependent as an unmarried Dependent child of any age who is medically certified as disabled and dependent upon the parent.

Kaiser Permanente will cover disabled, over-age Dependents if they are medically certified as disabled, dependent upon the Subscriber's spouse, and otherwise meet Membership requirements.

To qualify as a disabled Dependent, an Application for Disabled Dependent Coverage must be completed by both the Subscriber and the over-age Dependent's attending physician. Renewal of the application may be required by Kaiser Permanente annually.

Forms

When enrolling, the employee must complete the Enrollment/Change Form or CUE App, whichever applies. Employees must meet your Group's eligibility requirements and live within the applicable service area.

The Enrollment/Change Form and CUE App are also used for:

- Adding or canceling Dependents
- Name, address, and telephone number changes
- Canceling an account

Depending on your Group size, you may use the following forms:

- **Large Groups:** The Enrollment/Change Form is available in both English and Spanish.
  - A customized Group application form (preapproved by Kaiser Permanente).
  - Other prearranged, electronic enrollment methods
- **Small Groups:** The state-mandated (CUE App), which is available in both English and Spanish.

Please note: If your employee is covered by other health insurance, please indicate that in the "Other Insurance" section of the large Group Enrollment/Change Form, or in the "Employee/Dependent Waiver of Coverage" section of the small Group CUE App.

Enrollment *(continued)*

How and where to submit forms

Please send new enrollment applications as they occur. Timely notification of enrollment changes will ensure that:

- Members receive their identification cards in a timely manner;
- Member eligibility is visible to providers;
- Members are able to access care on their effective dates; and
- Billing adjustments will be processed and appear on the invoice in a timely manner.

We prefer to receive enrollment forms directly from you; however, we will accept these forms directly from your employees, unless you require that we accept them only from your office. Please let your account executive know about any specific instructions.

Mail

Return original completed applications to:
Kaiser Permanente P.O. Box 203009
Denver, CO 80220-9009

Secure email

If you have secure email, you may send the enrollment form to: **csc-den-roc-group@kp.org.**

Changes will appear on your next invoice.

Please note: Accounts with future eligibility dates will not appear until the applicable billing period.

Completing enrollment applications

Before submitting each form, please review it to ensure that it's complete, legible and accurate. In order to be processed efficiently, each form must include your Group's name, Group number, subgroup, employee's date of hire, and employee's effective date of coverage. (Refer to your Service Agreement Face Sheet for your Group/subgroup number.)

To ensure proper processing of enrollment information, the application must contain all of the below elements:

- Reason for change
- Name
- Relationship code
- Date of birth
- Gender (Male (M), Female (F) or Nonbinary (U))
- Address
- Effective date
- Group
- Subgroup
- Bill group
- Employee signature

If the above information is not included, or the application is incomplete or unreadable, the form will be returned to you for completion/correction. Coverage will not be effective until a properly completed enrollment form is received by Kaiser Permanente.

Special enrollment

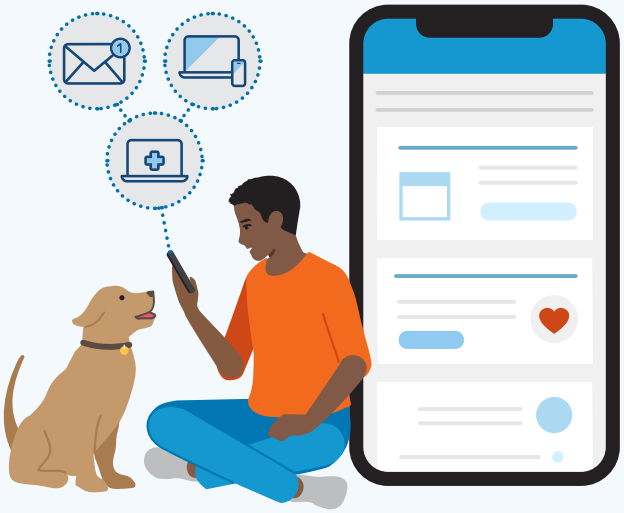
Eligible employees and their Dependents may enroll at times outside of your Group's open enrollment period by submitting an Enrollment/Change Form (for large Group Members) or the CUE App (for small Group Members). For information on qualifying events and effective dates of coverage, please refer to the Member's *Evidence of Coverage*.

Save time by managing your account online

With **account.kp.org**, our online administrative home for employers and agents, we make it fast and easy to stay on top of administrative tasks. You'll have 24-hour access to membership and billing information, so you can make updates whenever it's convenient for you.

Here are just a few of the features and benefits:

- **Manage membership:** Our newly redesigned Manage Members section lets you quickly enroll or terminate members and their families. Update addresses, order ID cards, and access handy administrative tools such as a downloadable membership roster.
- **View and pay bills online:** No more waiting for bills to arrive in the mail. Paperless billing lets you view pdf bills, download billing information in spreadsheet form, and sign up for email reminders. Never miss a payment with convenient, one-time or monthly automatic payment options.
- **View Group documents:** Key documents like the Summary of Benefits and Coverage are easy to access online. Not all documents are available in all regions.



Getting started is easy.

1. Visit account.kp.org
2. Choose the Employer or Broker view
3. Click on "Register" in the top blue header
4. Fill out the form and click submit

Once we receive the form, we'll send the user ID and password to the person designated as the Group administrator (Group primary user/primary administrator), within 7 business days.

If you're having technical issues with account.kp.org, we're here to help. Call **866-575-3562**, email **csc-sd-cas-web-support@kp.org**, or visit the Contact web manager page to get assistance with troubleshooting a specific problem.

Membership changes

Please notify us of any membership changes any time during the month. Changes include, but are not limited to, enrollment of new employees, addition or removal of Dependents, cancellations, or an employee's marriage, civil union, domestic partnership or divorce, etc. Easily make online changes via **account.kp.org**, where you can add, terminate or update member information.

Additions

Kaiser Permanente allows 60 days to retroactively add Members to a Group.

Cancellations

Colorado law prohibits retroactive terminations of Group Members. Premiums are payable through the date the member covered is no longer eligible if policyholder notifies Health Plan within 10 business days because the employee:

- Left employment without notice to the Group
- Was terminated for gross misconduct

Changes we may make

At times, Kaiser Permanente will initiate a membership change.

Examples include: This could include cancellation of a Dependent upon reaching the maximum age limit for Group coverage or receipt of an Enrollment/Change Form for large Group Members or a CUE App for small Group Members directly from your employee. **Please notify us if you do not want Kaiser Permanente to accept forms that have not been processed by you first.**

Where to send changes

Remember to notify us as quickly as possible of any adjustment, so we can keep your account current. In most cases, retroactive additions are limited and will not extend more than 60 days before the first of the month in which we receive them. Groups can process changes via **account.kp.org** for immediate updates.

Please send changes to:

Kaiser Permanente
Email: csc-den-roc-group@kp.org

Fax: 1-866-311-5974

Mail: Kaiser Permanente
P.O. Box 203004 Denver, CO 80220-9004

Changes will appear on your next invoice.

Please note: If terminations are not reported promptly, and Members use services before the termination is processed, Members will be billed at nonmember rates for services rendered.

Billing and payment

Kaiser Permanente is a **prepaid health plan.** Payment is due each month on or before the first day of the coverage month. This payment should include amounts due for new employees added to coverage, as well as new Dependents (if the addition to the family account increases the family's premium). Employee or Dependent accounts that remain unpaid for a 30-day period will be subject to cancellation.

Billing methods

Your Group may choose to receive monthly bills from Kaiser Permanente (called "Pay as Billed"), or track your own covered Members and calculate the premiums that are due (called "Self-billing"). Here are the details on each method.

- **Pay as billed** is our preferred method of payment and is also the easiest option for plan administrators. If your Group uses this method, when you receive your bill, please review it, report any changes, and pay the total amount listed as due. Please do not alter your premium payment to account for any changes. Any adjustments that you have made to your account will be reflected in the next billing cycle.
- **Self-billing** is a billing arrangement whereby the Group calculates covered Members and premiums, and sends the billing report to Kaiser Permanente. Please contact the Consolidated Service Center for more information on this method.

Understanding your billing statement

Statements are generated around the 10th of the month for the following month. If you require an earlier or later mailing, please contact your Membership Administration representative. Payments received after the first of the month may not be reflected on your invoice.

Your bill provides detailed information about your account in a simple, convenient format. This invoice format also includes indicators to help you easily identify Medicare information for Subscribers:

- A Medicare flag
- An itemized late enrollment penalty fee that is assessed to Members who enroll in Medicare Part D after the required due date
- An itemized low-income subsidy discount provided to Members who meet certain income and asset requirements established by the Centers for Medicare & Medicaid Services (currently not available in Southern Colorado)

Groups that receive our invoice are required to pay as billed. Enrollment changes and cancellations should be reflected correctly on your next billing statement.

If you have any questions about the bill format, Kaiser Permanente procedures, or the content of your bill, please contact a membership account representative in the **Membership Administration Department,** toll free, at **1-866-868-7220,** 7 a.m. to 7 p.m., Monday through Friday.

Payments when adding/removing members (billing cycle wash rules):

- If a Member is added by the 15th of the month, a premium is due on or before the end of the month. If a Member is added after the 15th of the month, no monthly premium is due.
- If a Member is canceled before the 15th of the month, no monthly premium is due. If a Member is canceled after the 15th of the month, a monthly premium is due.
- A request for an exception to these rules must be submitted in writing and must be approved prior to making any adjustments to your invoice. Written requests should be submitted to the attention of Sales.

Billing and payment *(continued)*

Payment options

Online payments at **account.kp.org** are easy and the preferred method of payment. However, we also accept premium payments by wire transfer, or check/money order.

Check or money order
If you choose to pay via check or money order, please send your payment to the following address and include your statement remittance or group number on your check. Send your payment to:

Kaiser Permanente
P.O. Box 711697
Denver, CO 80271-1697

Electronic:

- **Wire transfer or Automated Clearing House (ACH):** Bill payment using wire transfer or Automated Clearing House (ACH) has become widespread and offers benefits for both the sender and receiver of the funds. Your financial institution can help you decide whether one of these would be a good choice for your company. To initiate a wire transfer payment, please contact your account executive or membership administration.
- **Electronic Funds Transfer (EFT):** To sign up for EFT payments, please visit **account.kp.org** and choose the employer option. Then register for an account.
- **Online:** When you select our paperless billing option through **account.kp.org**, we'll email you when your bill is ready for viewing, and you can pay it electronically. (Getting started is easy, see page 13 for instructions.)

Non-sufficient funds

When a non-sufficient funds check (NSF) is received, the Group contact is sent a notice.

In this case, the group must:

- Send guaranteed funds to replace the NSF check within 5 working days; and
- Pay a processing fee of up to $100.

Cancellation procedures will be initiated if the payment and processing fee, if applicable, are not received, or payment arrangements are not made.

When a replacement payment is received for an NSF check, the payment is applied first to the processing fee, if applicable, and then to the debt.

Please note: Receipt of two NSF checks within a 6-month period will result in cancellation of the Group contract.

As a reminder, Kaiser Permanente is a prepaid health plan. In order to maintain coverage, payments should be received before the first day of each month. If full payment is not received, a Group contract can be canceled, and we will actively pursue recovery of all amounts due through all means permitted under state law. Partial payments will be deposited but will not prevent cancellation. There is no guarantee of reinstatement if a Group is canceled for nonpayment.

Timing

Late payments: Late payments may be subject to late fees and interest. If a Group fails to make past-due payments for the amount due after receiving an initial written notice from Kaiser Permanente, we may terminate the Group, upon written notice. When this type of termination occurs, the Group is liable for all unpaid amounts due through the termination date.

Paying claims

Claims are paid within 30 days of receipt by Kaiser Permanente. The entire claims process is described in the Member's *Evidence of Coverage*. The process is also documented in the Group Medical and Hospital Service Agreement, which is sent to Groups annually before their anniversary date.

Termination

Termination by Group

Your Group may terminate its Group Agreement, effective the day before any anniversary date, by giving at least 60 days prior written notice to Kaiser Permanente. Please contact your account executive if you have questions.

Please note: Discontinuation of premium payments is NOT considered an acceptable notification of cancellation of a Group policy. Groups will be responsible for premium payments until written notification to cancel is received from the Group.

Termination by Kaiser Permanente

Kaiser Permanente may cancel a Group for any of the following reasons:

- Fraud or for intentionally furnishing incorrect or incomplete information
- Violation of contribution or participation requirements
- No eligible person lives, resides, or works in the service area
- Nonpayment
- Nonacceptance of amendments

Non-payment

Except for the first payment for your Group's policy, a 31-day grace period applies to all payments. If payment is not made during the grace period, Kaiser Permanente may terminate your Group immediately after giving written notice.

- Groups that are canceled for non-payment must pay all premiums owed before being reinstated, rejoined, or enrolled as a new Group.
- Small Groups that are canceled for non-payment must wait 6 months from the date of termination to reapply. (All back-premiums must be paid prior to submitting a new application.)
- Groups that are canceled for non-payment twice, within a 12-month time period, will not be eligible for reinstatement.

If an employee loses coverage

When an employee or Dependent loses Group coverage, there are 2 options available to continue uninterrupted health plan coverage:

- Continuation of Group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), for Groups with 20 or more employee; or
- Under Colorado law when COBRA is not applicable. This is called State Continuation Coverage.

Employees who lose Group coverage may be eligible for one of our individual plans (Kaiser Permanente for Individuals and Families). Kaiser Permanente will send your canceled employees and their Dependents a letter notifying them of Group's cancellation. Notification is sent to the Subscriber's address. Terminated employees can visit **kp.org** to view available individual Kaiser Permanente Health plans.

More detailed information about continuation of coverage options can be found in the Member's *Evidence of Coverage*.

Termination *(continued)*

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent amendments require employers with 20 or more employees (except church employees) to offer continuation of Group coverage to employees and Dependents who lose Group coverage due to certain qualifying events.

Qualifying events

Covered employee:

- Voluntary or involuntary termination of employment, except for gross misconduct.
- A reduction in hours.

Covered spouse:

- Voluntary or involuntary termination of the covered employee's employment, except for gross misconduct.
- A reduction in hours.
- Divorce or legal separation from the covered employee.
- Death of the covered employee.
- The covered employee's entitlement to benefits under Medicare.

Covered dependent children

- Voluntary or involuntary termination of the covered employee's employment, except for gross misconduct.
- A reduction in hours.
- The covered employee's divorce or legal separation from his or her spouse.
- Death of the covered employee.
- The covered employee's entitlement to benefits under Medicare.
- The Dependent child no longer satisfies the Group's definition of a Dependent child.

Length of coverage

Canceled Group Members are eligible to continue coverage for up to 18, 29, or 36 months, depending on the reason for loss of coverage.

Eligibility

Who is eligible for COBRA for up to 18 months?

- Employees (and their covered Dependents) whose employment terminates for reasons other than gross misconduct.
- Employees (and their covered Dependents) who no longer qualify for Group coverage due to a reduction in hours.

Who is eligible for COBRA for up to 29 months?

- A Member who at the time of the qualifying event is determined by the Social Security Administration to be disabled during the first 60 days of COBRA coverage may continue coverage for up to 29 months. Members must notify the Group within the first 18 months of COBRA coverage and within 60 days after the Social Security disability determination.

Who is eligible for COBRA for up to 36 months?

- A divorced or legally separated spouse.
- A Dependent child who ceases to qualify for coverage.
- The surviving spouse and Dependent children of a deceased employee.
- The spouse and Dependent children of an employee who becomes eligible for Medicare. (Employees and Dependents who become eligible for Medicare are not eligible for COBRA.)

Termination *(continued)*

Administering COBRA

Employers must comply with COBRA or risk incurring penalties. You can administer COBRA for your Group, or you may select a third-party administrator.

Employees and their covered Dependents ("qualified beneficiaries") must be notified within 14 days of the COBRA-qualifying event date of their ability to elect COBRA continuation of coverage, and they must be provided with election forms.

Qualified beneficiaries have 60 days, from either the date of the qualifying event notification letter or from the loss of coverage date, whichever is later, to elect COBRA. Failure to elect COBRA within 60 days will sever a qualified beneficiary's entitlement to receive COBRA continuation coverage. Once COBRA continuation coverage is elected, there is a 45-day grace period to pay the initial premium payment.

Kaiser Permanente does not need to be notified until the COBRA period has ended and the enrolled employee and Dependents are to be canceled from Group coverage. We recommend that you cancel the employee's account at the time of the qualifying event and reinstate the account when COBRA is elected. If you want to have a separate bill group/billing unit for your COBRA participants, indicate on your invoice that the employee and enrolled Dependents should be transferred to the bill group/billing unit.

It is the Group's responsibility to notify Kaiser Permanente if a canceled Member is reinstated under COBRA. Clearly indicate on the Enrollment/Change Form or CUE App that the person is now a COBRA Member and the date of his or her reinstatement. Also add the person's name to the monthly statement.

COBRA administered by group or third-party administrator

After starting on COBRA, Members with COBRA coverage have 30 days to remit payment for their premiums. Please notify Kaiser Permanente of all late payments by the 15th of the month, following the month the payment was due (e.g., notify Kaiser Permanente by February 15 of payments that were due in January and not paid by January 31). In this example, the cancellation date of the Member's coverage would be effective at the end of February. If notification is made after the 15th of the month, we will follow the "Billing Cycle Wash rule" explained on page 15.

Colorado state continuation of coverage

C.R.S. § 10-16-108(2) was enacted to fill the gap left by federal COBRA continuation coverage. Colorado continuation of coverage applies to all employer groups, including those with fewer than 20 employees. Group continuation coverage is required to be extended to employees and their Dependents for up to 18 months. However, Dependents losing coverage due to meeting the age limit are not eligible for state continuation.

In order to be eligible, an employee must have been continuously covered under your plan for at least 6 months immediately prior to his or her termination from employment. Under state law, the termination can be for any reason. Continuation coverage must also be made available in the case of death or divorce.

An employer has up to 10 days after an employee's termination to notify the employee in writing of his/her right to continued coverage. An employee must notify the employer in writing of the employee's election to continue coverage and submit payment within 30 days from the date of termination.

Termination *(continued)*

Payment for continuation of coverage

Members should send their payments directly to the COBRA administrator, or to the employer if there is no COBRA administrator. Groups should send a single check to Kaiser Permanente for all dues owed (COBRA and non-COBRA).

Cancellation of continuation coverage

Termination of Group continuation of coverage under both federal and state laws occurs when:

- Member becomes covered under another Group health plan.
- Member becomes eligible for Medicare.
- At the end of the 18-, 29-, or 36-month period.
- Employer no longer provides Group coverage for employees.
- Employer cancels coverage with Kaiser Permanente.
- Group or Member fails to pay monthly premiums.

OBRA

The Omnibus Budget Reconciliation Act of 1987 (OBRA) allows a qualified disabled person to extend COBRA for an additional 11 months based on disability. Compliance with this Act is required of employers with 100 or more employees.

The law states that disabled employees and or disabled Dependents who are Medicare beneficiaries solely because of their disability, except those with end-stage renal disease (ESRD), are entitled to coverage under the same conditions as any employee under age 65.

If you are required to comply with this law, your employees and/or their Dependents who are disabled will have Kaiser Permanente as their primary carrier. Therefore, they should report to the administration that they have medical coverage through an employer.

OBRA requires Health and Human Services to establish a Medicare/Medicaid Coverage Data Bank to identify when an employer plan pays for benefits instead of Medicare or Medicaid. Employers will be required to provide certain information when they file W-2 forms with the IRS. Contact your account executive to discuss your compliance needs.

Form 1095-b, health coverage statement

- As part of the Affordable Care Act, all Americans who do not qualify for an exemption are required to have health insurance, or pay a penalty. This is sometimes referred to as the "individual mandate."
- 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. During the tax filing season (beginning in January of the applicable tax-year), Subscribers will receive a Form 1095-B. The form will provide Subscribers with information about their health plan coverage. The Subscriber may use the information on Form 1095-B to populate their health coverage history on their federal tax return.
- If a Subscriber has questions about the accuracy of their Form 1095-B, they should call Member Services at **1-844-477-0450.**

Kaiser Permanente 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 out-of-area benefit and fitness 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.

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.

Kaiser Permanente Senior Advantage (Medicare eligibility) *(continued)*

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, Kaiser Permanente 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.

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

Kaiser Permanente Senior Advantage (Medicare eligibility) *(continued)*

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.

Cards, forms and requests

Kaiser Permanente identification cards

After we receive and process a new Member's application, identification (ID) cards are generated and mailed to the Subscriber. Each enrolled family Member receives his/her own card. The card itself does not entitle a Member to services, nor does a Member need the card to obtain services.

- **Members:** Each Member is assigned a unique health record number (HRN), which is featured prominently on each identification card. The HRN is also sometimes referred to as a medical record number or Kaiser Permanente ID number.
- **Covered family:** Each Member of a family will have a unique Kaiser Permanente HRN. This number will not change, even if the Member changes Groups, changes Subscribers, or cancels and re-enrolls.
- **Replacing an ID card:** Members can call Member Services (see Important Contacts section of this manual) to replace lost identification cards. Members can also access their ID card online at **kp.org**, or through the Kaiser Permanente App, which is available for Apple and Android mobile devices.

In addition, an *Evidence of Coverage*, which details the exact benefits under the Member's plan, is available online. Members should sign on to **kp.org** with their user ID and password, then click on the "My Health Manager" tab near the top of the page.

Kaiser Permanente will only issue ID cards annually, if there is a change to your group coverage (i.e., benefit changes or copays). A new ID card will also be generated if there's a change to the employee's last name, year of birth, or addition of a new Dependent. Please be sure enrollment information is accurate upon submission, in order to avoid sending new ID cards to Members, unnecessarily.

Fraud

If a Member allows someone else to use his or her card, we have the right to keep the Member's card and terminate his or her membership. Any services rendered to nonmembers will be billed to that person at nonmember rates.

Form 5500/Schedule A

Membership Administration will supply Employee Retirement Income Security Act (ERISA) Groups with the information necessary to complete the Federal Form 5500, for tax purposes.

The Form 5500-related information will be mailed to the Group within 120 days after the end of the Group's contract year. If you have any questions, please contact your account executive (phone numbers can be found in the Contacts section).

Utilization requests

If you need utilization data, please discuss your request with your account executive.

Workers' compensation

For information regarding Workers' Compensation claims, call Member Services. You'll be directed to the appropriate business office for assistance. (Phone numbers can be found in the Important Contact Information section.)

Coordination of benefits (COB)

Coordination of Benefits (COB) is a way to simplify payment for medical care when an individual is covered by more than one health plan carrier. Individuals covered by more than one health care plan are entitled to certain benefit enhancements if they inform the carriers that they have multiple health plan coverage.

The rules of COB prevent health care providers from being paid more than 100 percent of their charges. The primary carrier pays its full benefit, and the secondary carrier pays its portion, if the services received are a covered benefit. If Kaiser Permanente is your secondary carrier and saves money because of COB, we will maintain a summary of savings in a benefit reserve account in the Member's name.

Any savings in the COB reserve account are available to pay for other health care expenses, covered in part by either plan during that calendar year. Expenses may include office visits or pharmacy copays. To have an expense considered for reimbursement, a receipt must be submitted.

State laws decide which carrier is primary. An easy rule of thumb is that the coverage carried with the individual's employer is the primary coverage. Coverage provided by a spouse's employer is secondary. In general, if children are covered under 2 plans, the "birthday rule" applies. The health care plan of the parent whose birthday falls earliest in the year (month/day) becomes the primary carrier for the children.

The benefits of a Member's plan do not apply to medical or hospital care, for which payment is available under any other primary carrier, such as Group medical, automobile or liability insurance. Kaiser Permanente will provide necessary care, but the Member must make a good faith effort to collect payment from these primary carriers by submitting Kaiser Permanente's nonmember billed charges to them.

In situations when a Kaiser Permanente Member (covered by another carrier as a Dependent) uses non-plan providers for medical services and files a claim with the other carrier, Kaiser Permanente is not liable for those charges. Kaiser Permanente benefits apply only when plan providers are used.

Kaiser Permanente will reimburse out-of-network (non-plan) providers or Members once a savings has been established. Non-plan providers will need to resubmit claims for processing. Members can submit receipts for out-of-pocket expenses to the Claims Department. Please see the Important Contact Information section of this manual.

Members who receive care through a Kaiser Permanente health plan for services covered by auto insurance or Workers' Compensation can have those services billed to the appropriate insurance company. The insurance and claim number information must be provided by the Member.

If a Member fails to cooperate with Kaiser Permanente in providing this information, the Member will be billed at full value of the charges. If it is determined these charges are not work-related or auto accident coverage is denied by an auto insurance carrier, charges will be covered by Kaiser Permanente up to the limits of that policy. Members will still be responsible for any applicable copays, deductibles, or coinsurance that is not covered by Kaiser Permanente.

Questions?

We're happy to answer your questions about COB. Call Patient Financial Services at **303-743-5900.** Representatives are available from 8 a.m. to 6 p.m., Monday through Friday.

Have questions?

Call us at 1-866-331-2091 or contact your agent or broker

account.kp.org

1253033419 December 2023