



California Large Group Administrative Handbook

Kaiser Permanente Membership Administration

INTRODUCTION

Welcome to the Administrative Handbook for California Commercial Large Group, your guide to administering Kaiser Permanente health benefits for your commercial group plan.

Please review this handbook and keep it as a reference. In it, you'll find important contact information, reporting instructions and requirements, billing and enrollment information, general guidelines regarding Medicare, COBRA, and Cal-COBRA, and a glossary of useful terms.

Our priority is always providing you with excellent customer service. If you can't find the information you're looking for or have any questions about this guide, contact your Account Management team or California Membership Administration.

MAKE THE MOST OF YOUR SMART DECISION

You've invested significantly in your business by providing your employees access to our integrated medical care delivery system. Now let's ensure you and your employees get the most out of everything we offer.

HERE'S HOW TO GET STARTED

Encourage your employees to register on kp.org and take advantage of our unique online services, such as emailing their doctor's office with questions, checking most lab results, and ordering prescription refills. Tools that enable your employees to manage their health care online can help cut down on time away from work, and that means higher productivity.

Check out our online account services at business.kp.org, an easy, secure, and time-saving way to manage your commercial group plan. Here, you can enroll employees, pay your premiums online, check the status of new changes to your account, and more.

Thank you for choosing Kaiser Permanente.

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IMPORTANT CONTACTS

<p>Membership Administration (MA)</p> <ul style="list-style-type: none"> ▪ Urgent enrollment requests ▪ Eligibility questions ▪ Payment reviews ▪ Billing and reconciliation inquiries ▪ Membership processing 	<p>MA Teams</p> <p>Large Accounts Phone: 800.731.4661, option 4 Fax: 855.355.5334 Email: CSC-LargeAccounts@kp.org</p> <p>National Accounts Phone: 800.731.4661, option 6 Fax: 855.355.5334 Email: CSC-SD-National-Services@kp.org</p> <p>Labor & Trust Phone: 800.731.4661, option 7 Fax: 855.355.5334 Email: CSC-SD-SA-LaborandTrust@kp.org</p> <p>Strategic Accounts Phone: 800.731.4661, option 7 Fax: 855.355.5334 Email: StrategicAccounts-TeamInbox@kp.org</p> <p><i>For better tracking, include your Group Name and Group ID (GID) and request type in the subject line; for example: Group Name - GID – customer request.</i></p>
<p>Administrative Support</p> <ul style="list-style-type: none"> ▪ HIPAA inquiries ▪ Tax ID requests, benefit plan inquiries, and COBRA interpretation ▪ Schedule A/5500 form and report requests 	<p>For Clients/Brokers - Client Services Unit (CSU)</p> <p>Phone: 866.752.4737 Fax: 951.549.3436 Email: CSU.CA@kp.org Hours: 8 a.m.–5 p.m. (Pacific Time) Monday-Friday</p>
<p>Electronic Files (EFI)</p> <ul style="list-style-type: none"> ▪ Assistance with questions, concerns, or issues related to file setup, file testing, or transmission ▪ Electronic file receipt confirmations and open enrollment file questionnaires 	<p>EFI Liaison</p> <p>Email: CSC-EFI-EM-Liaison@kp.org</p>
<p>Employee/Member Support</p> <ul style="list-style-type: none"> ▪ Online member account management ▪ Download forms and publications ▪ Facility locations and physician directories ▪ Health and drug encyclopedia 	<p>kp.org</p> <p>Member Services Phone: 800.464.4000</p> <p>Senior Advantage Member Services Phone: 800.443.0815</p>
<p>Escalated Service Issues</p> <ul style="list-style-type: none"> ▪ Issues not resolved through standard channels, for example, claims, billing, or access to care ▪ Member issues requiring additional assistance 	<p>For Clients/Brokers – CA Employer Broker Services (EBS)</p> <p>Phone: 877.762.8247 Email: CA.KP.EBS@kp.org Hours: 8 a.m.– 5 p.m. (Pacific Time) Monday-Friday</p>

<p>Your Account Management Team</p> <p>Account Manager Overall account responsibility, including:</p> <ul style="list-style-type: none"> ▪ Contract/policy renewals and changes ▪ Strategic planning and development ▪ Introduction of new products and benefits <p>Associate Account Manager Provides comprehensive support on:</p> <ul style="list-style-type: none"> ▪ Account administration ▪ Custom benefit summaries ▪ Enrollment materials and activities ▪ Health education outreach events 	<p>You will be assigned a designated California Account Manager and an Associate Account Manager who will be introduced during your initial administration meeting.</p>
<p>Web Support</p> <ul style="list-style-type: none"> ▪ Our Web Support team can assist with access questions and password resets for business.kp.org 	<p>Web Support Team</p> <p>Phone: 800.893.2971, option 3 Outside of California: 866.575.3562 Fax: 855.355.5334 Email: CSC-SD-CAS-Web-Support@kp.org</p>

MEMBERSHIP REPORTING AND GUIDELINES

PROCESSING YOUR REQUESTS

All membership transaction requests (e.g., enrollment, family change, termination) for new and existing members must be submitted online using business.kp.org, by an electronic media file, or on an enrollment/change form.

Note: Membership changes cannot be accepted over the telephone.

OPEN ENROLLMENT

During your open enrollment period, eligible employees can:

- Enroll in a Kaiser Permanente plan
- Make changes to their current benefits
- Add dependents to their coverage

Eligible employees must complete and sign a Kaiser Permanente Enrollment/Change form. Enrollment forms are not required for employees or their eligible dependents who are currently enrolled and are not making any changes.

Note: The process of collecting employee benefit elections through a method other than a Kaiser Permanente Enrollment/Change form must be reviewed and approved by the Operational Compliance Team at MA-Arbitration@kp.org annually.

QUALIFYING EVENTS

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

Kaiser Permanente will assume that the employer has completed eligibility verification and confirmation of the qualifying event. These events include:

- Marriage
- Addition of a domestic partnership
- Divorce or termination of a domestic partnership
- Birth
- Adoption of a child
- Death of a spouse, domestic partner, or dependent
- Court order
 - One of the following supporting court order documents must also be submitted to Kaiser Permanente
 - Health Insurance Coverage Assignment or Assignment Order (HICA)
 - National Medical Support Notice (NMSN) – Part A or B
 - Qualified Medical Child Support Order (QMCSO)
- A significant change in the health coverage of the employee, spouse, or domestic partner because of a change in the spouse's or domestic partner's employment

- An increase in an employee's hours worked that makes them eligible for medical coverage
- When an employee covered under a different plan moves out of the plan's service area
- When an employee moves from a job category in which Kaiser Permanente Insurance Company (KPIC) is not offered to a job category in which KPIC is offered
- When an employee who previously lived outside the Kaiser Permanente service area subsequently moves into our service area (this applies to POS members only)

MEDICAL RECORD NUMBERS

Medical record numbers (MRNs) are unique and an integral part of a Kaiser Permanente member's ongoing relationship and experience with the health plan. Multiple MRNs may lead to duplicate or incomplete clinical records and may result in delays when seeking medical care.

Note: Whenever possible, MRNs should be included on all documents and correspondence sent to Kaiser Permanente.

IDENTIFICATION CARDS

Identification (ID) cards will always be generated and mailed to:

- New Kaiser Permanente members
- Members with demographic changes (name or date of birth)
- Re-enrolling members whose enrollment generates a new card type due to a plan change
- Upon request
 - Members can request new ID card(s):
 - By calling Member Services at 1-800-464-4000
 - Members can also access their ID card information online through kp.org and the Kaiser Permanente App, which is available for Apple and Android mobile devices
 - Authorized group contacts can request new ID card(s):
 - Via business.kp.org

ID cards will not be generated or mailed if:

- A re-enrolling member has had an ID card generated for the same card/plan type within the last 13 months, and demographic data on the card is the same

Each enrolled family member receives a card. The card itself does not entitle a member to services, nor does a member need the card to obtain services.

OVERAGE DEPENDENT WITH A DISABILITY CERTIFICATION

Dependent children can stay on a group plan until age 26. An overage-dependent child who is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition that occurred before reaching age 26 and who is 50 percent or more dependent upon the insured for support and maintenance may continue coverage if they meet the eligibility certification requirements.

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

- Notify the benefits administrator
- Contact Kaiser Permanente at 1-800-731-4661 option 5 or by email to CSC-Overage-Dependent-CA@kp.org and request an Overage Dependent application
- Submit the completed application to the address indicated on the form

If you perform your own overage dependent certification, report the overage dependent to Kaiser Permanente as a Disabled Dependent (DI) using the existing enrollment procedures set forth in in your Group Agreement. If Kaiser Permanente currently performs the certification process, and you wish to assume this responsibility, contact your Kaiser Permanente Account Management team for more information.

LIVE/WORK PROVISION

Kaiser Permanente allows individuals who live or work in our service areas to enroll in a California Plan. The live/work provision applies to all non-Medicare subscribers, including COBRA subscribers. Live/work does not apply to Kaiser Permanente Senior Advantage.

The employer determines whether to offer the live/work provision. Kaiser Permanente will assume that eligibility verification — confirmation that the member lives or works inside our service area — has been completed by the employer. When an enrollment is received for a member outside of our service area, the enrollment will be processed.

Members who live outside our service area must receive covered services from plan providers inside the service area, except as otherwise described in the Evidence of Coverage. Per the Evidence of Coverage, we cannot enroll members who live in a Kaiser Permanente region outside of California.

Note: For more information about Kaiser Permanente's regions outside of California, contact your Kaiser Permanente Account Management team.

CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Certification of Creditable Coverage be issued to terminated members. Members with active status are also entitled to receive a HIPAA Certificate of Creditable Coverage upon written request within a reasonable time following submission.

The certification documents the health care coverage during Kaiser Permanente membership and is the primary resource that individuals use to prove prior creditable coverage when seeking new group coverage or coverage in the individual market.

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

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

BINDING ARBITRATION

Kaiser Permanente has used binding arbitration to settle member disputes since 1971. All members are required to agree to arbitration at the point of enrollment; groups are responsible for confirming that their employees have read and agreed to arbitration before submitting enrollment information for processing. To remain compliant with the California Health & Safety Code 1363.1 and Kaiser Permanente's Group Agreement for California, the Arbitration Compliance team must review and approve how each group collects employee benefit elections.

Kaiser Permanente's arbitration agreement must be included in all collection methods. Collection methods include:

- Kaiser Permanente enrollment forms
- Customer produced universal enrollment forms
- Online enrollment platform/web service
 - The California Arbitration Management System (CAMS) is a web service application developed by Kaiser Permanente to assist with capturing arbitration agreements at the point of enrollment. CAMS is available to all administrators who use an online enrollment platform (compatibility testing is required).
- Call center
- Telephonic/Interactive Voice Response (IVR)

The process of transmitting benefits elections from the collection method to Kaiser Permanente for processing is considered the reporting method. Reporting methods include:

- Electronic Data Interchange (EDI)/Electronic Media (EM) File
- Business.kp.org enrollments
- Completed enrollment forms via email, fax, or mail

For more information or to begin the review process, contact the Operational Compliance Team at MA-Arbitration@kp.org.

ONLINE ACCOUNT SERVICES – BUSINESS.KP.ORG

Your online home for group administration, business.kp.org, offers tools to manage membership, premium payments, and view important documents. Below are examples of the actions you can perform easily and securely using our online services:

- Enroll, update, or terminate employees and their dependents

- Submitting membership changes online is the fastest way to add or remove employees from your plan.
- Upload a spreadsheet to quickly enroll multiple members at once
- Order ID cards for an employee or a whole family
- Download an Excel-compatible membership roster for easy billing reconciliation
- Download monthly statements in PDF and/or Excel
- View financial activity reports, including online and offline payments
- Make one-time or recurring premium payments
- View your current contract, Evidence of Coverage (EOC) documents, and your Summary of Benefits and Coverage (SBCs)

Note: If you have not signed up for business.kp.org and would like to learn more, contact your Kaiser Permanente Account Management team to schedule a meeting. Please reference our complete [business.kp.org user guide](#) (PDF) for comprehensive instructions and functionalities.

ELECTRONIC DATA INTERCHANGE/ELECTRONIC MEDIA FILE REPORTING

The Electronic Data Interchange (EDI) process, also referred to as Electronic Media (EM) file reporting, provides Kaiser Permanente employer groups with an efficient and accurate way to communicate membership activity in a secure environment. Kaiser Permanente offers multiple transmission options that are accepted within the healthcare industry and follow current standards for secure transfer. The Health Insurance Portability and Accountability Act (HIPAA) ensures that there are standards and requirements for the maintenance and transmission of health information that identifies individual members. These standards are designed to improve the interchange of electronic data and to protect the security and confidentiality of personal health information (PHI).

Reporting via an EM file eliminates the need to send paper forms for processing. If you currently report to Kaiser Permanente via an EM file, be sure to use only this method when submitting membership changes and/or enrollments.

If you are interested in reporting eligibility using an EM file or you have any questions related to your file feed, contact our EFI Liaison team at CSC-EFI-EM-Liaison@kp.org.

OPEN ENROLLMENT ELIGIBILITY FILE QUESTIONNAIRES

To provide consistent messaging across all regions for Open Enrollment (OE) eligibility file inquiries, Kaiser Permanente has created a single guidelines document. The Open Enrollment File Guidelines document addresses 16 of the most common OE topics, including contacts, dual-year processing, file confirmations, and ID cards.

To request a copy of the Open Enrollment File Guidelines or to address additional eligibility file questions, contact our EFI Liaison team at CSC-EFI-EM-Liaison@kp.org.

ELIGIBILITY DISCREPANCY REPORTS

Questions or inconsistencies found while processing your membership activity via an EM file will result in a discrepancy report being created. The eligibility contact on file will receive discrepancy reports via email when applicable.

To keep processing delays and retroactive adjustments to a minimum, make the required changes on your next EM file and/or respond to the discrepancy report as soon as possible.

Note: Send eligibility contact updates to your Kaiser Permanente Account Management team. If your eligibility administrator is changing or has recently changed, email your Account Management team and the designated Membership Administration team with updated contact information.

AUTOMATIC ELIGIBILITY EM FILE COMPLETION NOTIFICATIONS

Kaiser Permanente provides automatic email confirmations when your California EM eligibility file has been completed. Confirmations include the following details:

- The date the eligibility file was received
- The date the eligibility file was completed
- The number of customer-reported records that were received on the file
- The active subscriber membership count when the file was completed
- The active dependent membership count when the file was completed
- All Purchaser/Group ID numbers included in the file
- A contact number for customer questions
- When applicable, an eligibility discrepancy report (EDR) will be attached

Contact your designated Membership Administration team to update the email recipients for these notifications.

TERM BY OMISSION

Kaiser Permanente's preference for terminating members on an EM file is to explicitly report termination dates. However, if members are dropped from the file (terminated by omission), they will be terminated using the contract rules set forth in your group agreement.

In most cases, Kaiser Permanente will terminate members who are dropped from the EM file. There are a few scenarios where you may receive proactive outreach or see these coded as discrepancies instead, such as:

- COBRA members
- Overage Dependents/Disabled Dependents (DI)
- A threshold of 20% dropped members, at the subgroup level, is exceeded

Note: Once a member is terminated using this method, you will not receive notification on a discrepancy report.

TERM BY OMISSION: REGULAR PLAN YEAR REPORTING

When terminating omitted members, Kaiser Permanente uses the file receipt date as the termination date in combination with the contract rules set forth in the group agreement. For example, if a member is dropped from a file received on 12/15, the termination date will be processed in accordance with the contract rules below:

- “End of month”: Member’s first day of no coverage will be 1/1
- “Any Day”: Member’s first day of no coverage will be 12/15

TERM BY OMISSION: OPEN ENROLLMENT REPORTING

We understand that open enrollment (OE) requires adjusted processes to ensure timely ID card generation and access to care. For that reason, we have implemented a process that attempts to systematically identify OE files and ensure dropped members do not terminate until the end of the plan year.

If you send an 834 file, you can assist us in identifying your file as OE by entering the open enrollment effective date in the “BGN03” field. This is also commonly referred to as “the header field.” When resuming your current plan year files, resume using the file creation date in this field.

To be certain your members terminate on the correct day, it is best to explicitly report termination dates for each member rather than dropping them from the file.

ENROLLMENT/CHANGE FORM

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

- Enrollment forms may be delayed or rejected if submitted with missing or inaccurate information.
 - Review all enrollment forms for completeness and accuracy before submission to ensure that all enrollment requests can be processed promptly.
 - The items listed below show the sections on the enrollment/change form that must be completed for your membership request(s) to be processed:
 - First and Last Name
 - Address
 - Date of Birth
 - Social Security Number
 - Gender
 - Purchaser/Group ID
 - Subgroup/Enrollment Unit ID
 - Signature
 - Signature Date
 - Effective Date
 - Previous Kaiser Permanente MRN (if applicable)
 - Dependent Role
- All enrollment requests must be dated and signed by the subscriber.

- Completed forms should be emailed or faxed to Membership Administration at the appropriate address or fax number found on the Important Contacts page of this handbook.
 - Completed forms can also be mailed to Member Administration; however, mailing your forms can delay the processing turnaround time.
 - If forms are faxed or emailed, it is not necessary to mail the original document.

TERMINATIONS

Terminations can be reported using your normal reporting method or a Kaiser Permanente termination form. To prevent processing delays or rejections, terminations must include a termination effective date within the retroactivity limit set forth in your group agreement. Please note:

- When a subscriber is terminated, the entire family account is terminated
- The termination date is determined by the contract termination rules set forth in your group agreement
 - Our eligibility system will automatically terminate an overage dependent's membership based on the eligibility provision in your group agreement.
- Please do not use a payment instruction file or statement as your only method of reporting terminations, as they may not be processed using this method
- During open enrollment, terminating an entire population for the current plan year with the intent to re-enroll only those continuing coverage is not advised
 - For EM files, we have safeguards in place to prevent this, however, we cannot guarantee the population will not be terminated if this occurs. If a significant population of your members is reported as terminations, you may receive outreach from a representative confirming your intent. Please respond promptly so we can ensure accurate processing.
- If reporting electronically, our system will populate the file receipt date as the termination date for members who are dropped from the file (no termination date explicitly reported).
 - For open enrollment files, our system will attempt to terminate dropped members effective at the end of the plan year; however, explicitly reporting termination dates is ideal.

TRANSFERS

Kaiser Permanente allows employers to change a member's plan type or subgroup ID (transfer) during open enrollment or a qualifying event. The employer must notify Kaiser Permanente of member transfers within the retroactivity limit set forth in your Group Agreement (except for Kaiser Permanente Senior Advantage).

Note: If reporting electronically and sent correctly, transfers should not result in members being terminated or receiving termination notices. However, if the original effective date is provided for transfers, there is a risk that the member will be terminated from their existing plan without being subsequently enrolled in their new plan.

RETROACTIVITY

Kaiser Permanente allows for members to be enrolled, reinstated, terminated, and transferred within the retroactivity limit set forth in your group agreement. Please note:

- For billed groups, the membership changes will appear on your monthly billing statement
- For self-billed groups, you should report the changes on your next payment instruction file
- If you attempt to enroll or terminate an employee outside of the retroactivity limit set forth in your group agreement, you will be asked to submit an official exception request
 - Depending on the timeframe being requested, it may require different levels of approval, and turnaround times will vary.

BILLING AND PAYMENT METHODS

There are two monthly billing options available.

- Billed: Kaiser Permanente generates and provides a monthly statement to you or your TPA.
- Self-billed: You or your TPA can track the covered members and calculate the premiums that are due to Kaiser Permanente every month.

Note: Additional details and requirements for each method are below.

BILLED

If your group uses our billed method, your monthly statement will be available online at business.kp.org. The monthly bill you receive is associated with a specific activity period. Billed customers are expected to pay 100% of the total current and retro dues as listed on the statement.

To maintain accurate billing records, do not alter your premium payment to account for any membership changes. Membership changes that were processed after the billing cut-off for your activity period will appear on your next billing statement.

SELF-BILLED

Self-billed customers report their membership to Kaiser Permanente on a regular basis, then pay their calculated premium amount monthly, along with specific instructions for allocating that payment. Kaiser Permanente's team then reconciles the eligibility and allocation information against our systems and reports any discrepancies back to the group administrator for correction.

Self-billing is a significant administrative commitment that requires detailed, time-sensitive submissions on an ongoing basis. This arrangement is not recommended for most groups. If requirements are not consistently met, your group may be transitioned to a standard billing arrangement.

To be eligible and approved for self-billing, your group must agree to and meet the following requirements:

- Maintain at least 250 eligible members
 - Your group must maintain at least 250 eligible employees nationally. You are responsible for notifying your Account Manager at renewal if your eligible membership falls under the minimum.

- Submit timely membership eligibility reports via Electronic Media files
 - Your group must submit one full Electronic Media file monthly, which lists all eligible members. If changes are needed before the next monthly full file, we recommend submitting a weekly change file that includes only the members whose information needs updating.
 - Membership files must include the following information for all subscribers: a valid unique identifier, Social Security Number (SSN), and/or Employee Identification Number (EEID).
 - Membership files require sign-offs for successfully passing testing and audit procedures before a self-billed arrangement can be approved. Any changes to file templates will require additional testing and may cause delays.
- Submit correct payments with Payment Instruction Files (PIF) for allocation
 - Submit your premium payment by the 1st of each coverage period.
 - Current commercial plan and Medicare membership rates must be paid.
 - Each PIF must have a single matching premium payment.
 - PIFs must be provided in a Kaiser-compatible premium Electronic Media file or a Kaiser Permanente proprietary spreadsheet template.
 - Valid unique subscriber identifiers must match what is reported via the membership Electronic Media files.
 - If payment for a subscriber is not received for three (3) consecutive months of coverage, Kaiser Permanente will conclude that this subscriber and any family members should have their coverage terminated.
 - PIFs will need signoffs for successfully passing testing and audit procedures before a Self-billed arrangement can be approved. Any changes to file templates will require additional testing and may cause delays.
- Resolve any discrepancies on time
 - Kaiser Permanente will provide a monthly premium reconciliation discrepancy report through secure email to the authorized contacts on file.
 - The discrepancy report will itemize any open discrepancies, regardless of the coverage month in which discrepancies were created. Discrepancies will continue to be reported until they are fully resolved.
 - Discrepancies can be resolved by paying the outstanding amount due, taking credits, correcting the membership file, and/or submitting missing documentation.
 - Discrepancies must be reviewed and resolved on the following month's PIF or by updating the membership on their next eligibility file.

Note: Groups that utilize the self-billed method will not receive a monthly billing statement from Kaiser Permanente.

For further details about self-billing, including payment practices, contact your Kaiser Permanente Account Management team.

PREMIUM DISCREPANCY REPORTS

Questions or inconsistencies found while processing your PIF will result in a cumulative discrepancy report being created. After the monthly self-billing reconciliation has been completed, the billing contact on file will receive a cumulative discrepancy report via email. This report contains all discrepancies that are open for your account, regardless of the coverage month in which the discrepancies were created. Member information, discrepancy types, and associated premiums are included within the cumulative report.

Discrepancies must be reviewed and resolved promptly. If a payment is not received for three (3) consecutive months of coverage, Kaiser Permanente will conclude that the member or members should have coverage terminated. The following discrepancy types indicate payments have not been received:

- No payment made
- No payment received

For additional information, refer to the [Premium Reconciliation Discrepancy Report Reference Guide \(kp.org\)](#).

PAYMENT OPTIONS

Kaiser Permanente offers a variety of payment options to fit your business needs. Payment may be remitted online via [business.kp.org](#), automated clearing house (ACH), wire transfer, or check.

To ensure accurate identification and allocation of payment, submit one payment per billing statement or PIF. Please note: If you're a billed customer, include your Billing ID number on all documents. If you're a self-billed customer, include your Group ID on all payment submissions.

PAYING ONLINE THROUGH BUSINESS.KP.ORG

To best serve you, we encourage you to use our online portal at [business.kp.org](#), the fastest and most efficient way to make premium payments. The "Manage Payments" feature ensures payments are posted quickly and accurately. There are three ways to pay your premium using this method:

- Autopay (billed groups only)
 - Each month, the total amount due on your billing statement will automatically be withdrawn from your account one to five days before your payment due date.
 - ❖ Recommendation is to set up autopay to withdraw 4 to 5 days in advance of the due date
- One-time and one-time future payments
 - Log onto [business.kp.org](#) and submit a one-time payment or schedule a one-time future payment using "Manage Payments."
 - You have the option to schedule a monthly email notification that lets you know when your statement is ready to view online

If you're currently a registered user of [business.kp.org](#), you can view and pay your monthly statement online.

If you've not yet signed up for business.kp.org and would like to learn more, contact your Kaiser Permanente Account Management team to schedule an administrative meeting.

PAYING BY AUTOMATED CLEARING HOUSE (ACH) PAYMENTS OR WIRE TRANSFERS

ACH payments and wire transfers are electronic transfers of funds between your financial institution and Kaiser Permanente's bank. ACH payments generally have reduced processing costs and take one to three business days to settle. Wire transfers settle the same day.

Contact your bank to set up an ACH (CCD+ format) payment or wire transfer using the below California banking information:

- Account number: 001416416461
- Active ACH Blocks/Filters on file: Yes
- Routing number ACH: 121000358
- Routing number DOM. WIRES: 026009593
- SWIFT Code INTL WIRES: BOFAUS3N (U.S domestic) BOFAUS6S (foreign currency)
- Account name: Kaiser Foundation Health Plan
- Account address: Kaiser Foundation Health Plan Inc., 393 E Walnut Street, Pasadena, CA 91101

Submit separate ACH or wire payments per billing statement. To ensure accurate identification and allocation of payment, ensure your bank includes your Billing ID number and company name in the payment details ID/name field of your ACH payment or wire transfer. This field has a limit of 37 characters, so ensure your bank denotes your Billing ID number first, followed by your company name. For example, if your Billing ID is 1234567890, then the payment details field will read: BID 1234567890 ABC, Inc.

Your Billing ID number is located on the first page of your billing statement in the top right-hand corner. Please note, you may have more than one Billing ID depending on your billing setup.

If you have questions about your billing setup, contact your Kaiser Permanente Account Management team. If you need an ACH vendor form completed and signed, contact the Kaiser Permanente Remittance team at CSC-SD-Remittance@kp.org.

PAYING BY CHECK

To prevent check-related allocation delays, pay online at business.kp.org or via ACH. If you're unable to pay online or via wire transfer, and will continue to pay monthly premiums by check, mail your payment 7 to 10 days before your statement due date to ensure timely processing. Separate check payments must be remitted for each billing statement.

- Prepare a check or checks made payable to Kaiser Foundation Health Plan, Inc. for the total amount due
- Write your Billing ID on your check(s)
 - Your Billing ID number is located on the first page of your billing statement in the top right-hand corner. Please note that you may have more than one Billing ID depending on your billing setup.

- Mail your check(s) with the remittance advice (lower portion of the last page of your statement) before the due date. Do not modify or include allocation instructions on the remittance advice. Mail to:
 - Kaiser Foundation Health Plan, Inc.
P.O. Box 741562
Los Angeles, CA 90074-1562

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

IMPORTANT TIPS FOR STAYING CURRENT

Kaiser Permanente is a prepaid health plan. If payment is not received within fifteen days of the due date, a delinquency notice will be sent stating we have not received full premium payment and your account may be subject to termination. Hard copy delinquency notices are sent to the contract signer, billing contact, and your broker when payments are not received timely. Notices are also available for download on business.kp.org. Kaiser Permanente reserves the right to assess a late fee permitted by applicable law.

Helpful tips to keep your account current:

- Pay online via autopay on business.kp.org
- Submit one payment per billing statement
- Include your Billing ID number(s) on all documents and payments
- Review payment details on your statement monthly to confirm payments are posted correctly
- Submit premium payments by the due date
 - Recommendation is to submit payment 4 days in advance of the due date for ACH/Wire payments and 7 to 10 days in advance of the due date for check payments.
- Pay the "Total Amount Due," which includes current dues, retroactive dues, and any previous balances
- Avoid manually factoring in membership changes before they appear on statements
 - Manually factoring in membership changes causes discrepancies and may create a rolling balance or put your account at risk for delinquency termination.

MEDICARE AND KAISER PERMANENTE SENIOR ADVANTAGE (KPSA)

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

- Individuals aged 65 and older
- Individuals with certain disabilities
- Current Kaiser Permanente members with end-stage renal disease (ESRD)

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

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

MEDICARE PART A

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

MEDICARE PART B

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

MEDICARE PART D

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

KAISER PERMANENTE MEDICARE PROGRAM

MEDICARE ADMINISTRATION

- Administered through the federal Centers for Medicare & Medicaid Services (CMS) and local Social Security Administration (SSA) offices.

- CMS contracts with healthcare providers, such as Kaiser Permanente, to manage healthcare services for Medicare-eligible members.
- SSA offices accept applications for Medicare and assist beneficiaries with entitlement, enrollment, claims, and premium problems.

KAISER PERMANENTE SENIOR ADVANTAGE

- Kaiser Permanente’s Medicare plan is called Kaiser Permanente Senior Advantage.
- Coverage for current and prospective Kaiser Permanente members entitled to Medicare Part A and enrolled in Medicare Part B, or enrolled only in Medicare Part B.
- Coverage is provided for urgent care when the Medicare beneficiary is outside a Kaiser Permanente service area (this is in addition to other CMS-mandated benefits).

Unlike Medicare, Kaiser Permanente also provides coverage to enrolled Medicare beneficiaries for emergency care anywhere in the world. Unless otherwise referred to or authorized by Kaiser Permanente, members must receive all non-emergency health care services from Kaiser Permanente. Neither Kaiser Permanente nor Medicare will pay for unauthorized routine out-of-plan services.

KAISER PERMANENTE SENIOR ADVANTAGE WITH THE RETIREE DRUG SUBSIDY

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

KAISER PERMANENTE SENIOR ADVANTAGE WITH PART D

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

VALUE TO THE MEMBER/EMPLOYEE

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

Kaiser Permanente Senior Advantage benefits include:

- No need to find physicians who accept Medicare assignment
- No Medicare-disallowed charges for covered services

Kaiser Permanente Senior Advantage includes the following benefits not covered by Medicare:

- Routine physical examinations
- Routine immunizations
- Hearing examinations, eye examinations, lenses, and frames
- Health education
- Emergency coverage outside the U.S.

- Dental care (if employer subscribes)

MEDICARE ELIGIBILITY

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

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

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

Medicare Part D is open only to those persons who are entitled to Part A and enrolled in Part B, or entitled to Part A and/or Part B.

KAISER PERMANENTE SENIOR ADVANTAGE ELIGIBILITY

- Individuals must be entitled to Medicare Part A and enrolled in Medicare Part B, or enrolled in Part B only, to be eligible to enroll in Kaiser Permanente Senior Advantage.
- Current Kaiser Permanente members or prospective members who live in a Kaiser Permanente Senior Advantage service area

KAISER PERMANENTE MEMBER AGE-IN PROGRAM

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

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

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

NOTIFICATION TO EMPLOYER OF PROSPECTIVE KAISER PERMANENTE SENIOR ADVANTAGE MEMBERS

Members must enroll in our Kaiser Permanente Senior Advantage program to receive the lower monthly premium. Those members who enroll and those who do not enroll but are eligible will be reported to you via the Monthly Medicare Activity Report. If you are not receiving this report, you can request it through your Kaiser Permanente Account Management team.

FEDERAL COBRA AND CAL-COBRA PROCEDURES

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

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

Under the Employee Retirement Income Security Act (ERISA), the employer's Employee Welfare Benefit Plan has the fiduciary responsibility for all aspects of COBRA administration. The Plan Administrator (as defined by ERISA) is the employer, or a Third-Party Administrator (TPA) appointed by the employer. Kaiser Permanente performs only clerical COBRA functions for employer groups. It has not and does not accept fiduciary responsibility as a COBRA administrator for any employer group.

Kaiser Permanente is, however, a Plan Fiduciary (as defined by ERISA solely) for determining the scope and extent of health care coverage for those ERISA Plan beneficiaries enrolled through the group as our members, including those participating through COBRA. If your employees call Kaiser Permanente for Federal COBRA enrollment information, they will be told to contact their employer for assistance.

ENROLLING FEDERAL COBRA MEMBERS

Kaiser Permanente COBRA enrollment forms are available upon request.

When an employee or dependent chooses to elect Kaiser Permanente COBRA coverage, report elections in the way you usually submit membership changes. Kaiser Permanente will not accept any COBRA enrollment requests directly from the member.

Members who intend to elect to pay for COBRA coverage may use Kaiser Permanente services during the interim between their termination from health coverage and their enrollment into COBRA. You should make them aware of the following:

- If the individual uses services but does not elect to pay for Kaiser Permanente COBRA coverage, Kaiser Permanente will bill the individual as a nonmember for all services received

FEDERAL COBRA MONTHLY PREMIUMS

The Employer Group or delegated TPA is responsible for billing and collecting COBRA payments from members.

Kaiser Permanente will collect premiums from the employer for all COBRA members. Premiums will be due for your members as a group. It is expected that one monthly payment for all COBRA members will be remitted. Do not send separate payments for each COBRA member.

FEDERAL COBRA TERMINATION

The duration of time a member is eligible for Federal COBRA varies. As such, when submitting a COBRA enrollment, include the end date for coverage eligibility.

TERMINATION OF EMPLOYER CONTRACT

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

EMPLOYEE NOTIFICATION

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

Kaiser Permanente will notify members who have exhausted their Federal COBRA coverage (if they are entitled to fewer than 36 months of Federal COBRA) of their opportunity to enroll in Cal-COBRA and extend the term of their continuation coverage to 36 months. The notice is included with other options that may be available. If your employees have any questions about Cal-COBRA, have them contact Member Services.

CAL-COBRA

The California Continuation Benefits Replacement Act (Cal-COBRA) allows continued access to group health coverage for up to 36 months to:

- Former employees and their dependents of employers of 2 to 19 eligible employees (including church groups)
 - A dependent who loses group coverage due to divorce or legal separation.
 - A dependent who loses group coverage due to the death of the subscriber.
 - A dependent child who marries or reaches the age limit for group membership or who experiences a change in custody.
 - A dependent at the time a subscriber becomes entitled to Medicare.
 - Excludes former employees and their dependents if loss of coverage is due to gross misconduct. If the loss of eligibility is due to gross misconduct, employers should notify Kaiser Permanente within 5 business days.
- Enrollees who have exhausted continuation coverage under Federal COBRA and were entitled to less than 36 months of Federal COBRA

CAL-COBRA EMPLOYEE NOTIFICATION

Kaiser Permanente sends a notification of Cal-COBRA to all eligible group members terminating group health care coverage. The notice is included with other options that may be available. If your employees have any questions about Cal-COBRA, have them contact Member Services.

CAL-COBRA MONTHLY PREMIUMS

Kaiser Permanente manages the billing for Cal-COBRA. Bills are sent to the subscriber's home address on file, and payment is collected directly from the subscriber.

COBRA ACTIVITY REPORT

Kaiser Permanente provides a COBRA activity report for every month in which you have Federal COBRA enrollees that are billed by Kaiser Permanente, and/or Cal-COBRA membership activity.

The report will:

- Help you comply with your Federal COBRA fiduciary responsibilities, including notifying qualified beneficiaries of their Federal COBRA rights and processing Federal COBRA elections
- Support you in providing a Summary of Benefits and Coverage (SBC) for all Federal COBRA and Cal-COBRA enrollees, as required by the Affordable Care Act (ACA)
- Identify which of your enrollees do not have a stop date to indicate the COBRA eligibility duration
 - Until a stop date is set, enrollees will continue to be billed for premiums unless the enrollee requests termination.

The report lists:

- Your Federal COBRA enrollees who are billed by Kaiser Permanente
- All of your Cal-COBRA enrollees
- Enrollees who have failed to make timely payments
- Enrollees who are being terminated, either for nonpayment or for reaching the maximum period of Federal COBRA continuation coverage

GLOSSARY

Account Manager

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

Activity Period

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

Balance

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

Billing Cycle

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

Billing Date or Billing Schedule

The actual cutoff day for transactions used in dues-owed calculations for billed employers. The billing frequency and billing date together define the activity period for a specific billing unit.

Billing Unit (BU), Enrollment Unit (EU), or Subgroup

A number tied to a specific set of rates and benefits within a group number (Purchaser ID). Subgroup numbers allow for groupings of specific populations with their unique billing parameters (billing address, billed vs self-billed, etc.) and enrollment type (actives, retirees, and COBRA).

Broker

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

business.kp.org

Kaiser Permanente's online account service portal allows employers to maintain membership, pay dues, and view eligibility and billing information.

California Continuation Benefits Replacement Act (Cal-COBRA)

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

- Qualified former employees, and their dependents, of employers of 2 to 19 eligible employees (including church groups).

- Enrollees who have exhausted continuation coverage under federal COBRA; if the enrollee is entitled to less than 36 months of Federal COBRA (the total months of continuation coverage under both Federal COBRA and Cal-COBRA will not exceed 36 months).

Centers for Medicare & Medicaid Services (CMS)

The federal agency that administers the Medicare program.

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

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

COBRA

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

Contract

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

Contract Option

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

Contract Version

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

Coverage

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

Coverage Effective Date

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

Customer/Employer

An individual, organization, regulatory organization, or association that signs or may sign (prospect) a contract with Kaiser Foundation Health Plan, Inc. to provide health care benefits.

Customer Service Center (CSC)

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

Dependent

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

Dues

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

Effective Date

The date that the services provided in the contract begin.

Eligibility Requirements

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

Eligibility Rules

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

End-stage renal disease (ESRD)

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

Evidence of Coverage (EOC)

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

Group Agreement

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

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

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

Health Plan

Kaiser Foundation Health Plan, Inc. (KFHP), a California nonprofit corporation.

Identification (ID) Card

A membership identification card that shows the member's medical record number, which identifies medical records and membership information.

Kaiser Permanente Insurance Company (KPIC)

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

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

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

Membership Administration Consultants (MACs)

A consultant who represents the California Service Center, our membership administration department, in the field. MACs work closely with the Account Management team, customers, and the CSC to find solutions from our wide array of reporting options and billing and eligibility tools. MACs can provide hands-on training sessions about our administration guidelines and our online account services site.

Member

An individual who is eligible to receive medical services and benefits, is enrolled under the Evidence of Coverage (EOC), and for whom we have received applicable dues.

Member Services Contact Center

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

Membership

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

Non-sufficient funds (NSF)

How checks are designated when they are returned from the bank for non-sufficient funds.

Open Enrollment

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

Overage dependents

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

Payment Due Date

The date by which payment is expected. Based on the designated billing schedule, the billing date will be calculated on the last day of the activity period, with a due date of the first day of the coverage period.

Policyholder

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

Premium

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

Qualifying Event

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

Rate Change

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

Reconciliation

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

Remittance Advice

A remittance advice is a payment coupon to send with a check payment that contains information relating to the payment, such as Billing ID, billed amount, paid amount, and coverage period.

Retroactivity

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

Service Area

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

Subscriber

1. A person on his or her own behalf and not by virtue of dependency status who, as either an employee or an employer or as a subscriber, is accepted for enrollment and continuing coverage, who meets all the acceptable eligibility requirements, who is enrolled, and for whom payment or a guarantee of payment has been received by the health plan.
2. A member who is eligible for membership on his or her behalf and not by virtue of dependent status, and who meets the eligibility requirements as a subscriber.
3. The subscriber "governs" the account, and certain transactions applied to the subscriber account record will cause a change to all the member records within the account, such as a membership address change. A change to the subscriber's personal information (e.g., a birth date change) will only change the subscriber's record and not any member records within the account.

Termination

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