Maryland and Virginia

Small Business Administrative Guide for Off-Exchange Plans 2026

Resources and information to help manage your account

KAISER PERMANENTE®

The information in this handbook applies to small group off-exchange plans, purchased directly through Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS; Kaiser Permanente). The information is specific to care and services received through KFHP-MAS. If you or your employees are enrolled in one of our Kaiser Permanente Flexible Choice or Added Choice plans and/or need additional information that is not included in this handbook, please refer to your *Evidence of Coverage* and/or *Certificate of Insurance* or contact your broker or group account manager.

Your *Group Agreement* and *Evidence of Coverage* contain the terms of your contract. Consult the *Group Agreement* and *Evidence of Coverage* to determine governing contractual provisions including detailed benefits, exclusions, and limitations related to the group benefit plan. The *Group Agreement* and *Evidence of Coverage* is the legally binding document between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and groups. In the event of ambiguity or a conflict between this handbook and the *Group Agreement* and *Evidence of Coverage,* the *Group Agreement* and *Evidence of Coverage* shall control.

The information contained within this document is considered proprietary and should not be shared with anyone other than the intended recipient. This information is intended only for the personal and confidential use of the individual or company to whom it is issued and may contain information that is privileged, confidential, and protected by the law. If you are not the intended recipient, you are hereby notified that any use or disclosure of the information contained herein is strictly prohibited. If you have received this information in error, please notify Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., immediately. Your compliance with this request is appreciated.

Table of Contents

I. WELCOME TO KAISER PERMANENTE

Dear Employer,

Thank you for choosing Kaiser Permanente to help you build a better future for your business. You've made an important investment by offering your employees the convenience and care of Kaiser Permanente's integrated model of health coverage. Now it's time to get an even better return on your investment by making sure you and your employees get the most out of everything we offer.

As your partner in health, we're committed to providing the quality care and support you and your employees need to stay healthy and productive. After all, healthy employees are essential to any company's success. With Kaiser Permanente, you have a health care partner that addresses the health of your employees early, consistently, and effectively—leading to lower overall costs, healthier and more productive employees, and improved performance for your company.

You're a valued partner and we're here to support you and provide the information you need to easily manage your Kaiser Permanente health plan. This administrative guide provides the resources and tools you need to simplify the administration of services for you and your employees—from enrollment, invoices, and claims to medical center locations, important contact information, and more.

We encourage you to read through this guide and keep it as a reference to help manage your health care account throughout the year. Of course, if you have any immediate concerns or needs, please contact your account management team. We're here to help.

Sincerely,

Ashley D. Schneider
Director, Small Group Sales and Account Management
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

References to "partner" in this brochure do not imply a legal partnership or affiliation with small group employers doing business with Kaiser Permanente.

II. GETTING STARTED

1. Encourage your employees to register at **kp.org** so they can take advantage of online services:[1]
   - selecting or changing their doctor
   - emailing their doctor's office with questions
   - managing appointments
   - checking most lab results
   - ordering most prescription refills
   - getting advice from a registered nurse 24 hours a day
   - setting up a video or phone visit[2]
   - requesting ID cards

   These tools enable your employees to manage their health care online and can help cut down on time away from work. That means higher productivity by keeping your employees—and your bottom line—healthy.
2. Pay your bills online and enroll members with (**business.kp.org**) and online bill payment (**business.kp.org/business/employer/manage-accounts**) sites. You can enroll your employees, pay premiums, check the status of new changes to your account, and more.
3. Read through this guide and keep it as a reference. It contains important information, including how to enroll employees and dependents, terminate employees and dependents, understand and pay your bills, and more.

[1]Certain services offered on **kp.org** are available only for care and services received at Kaiser Permanente facilities.
[2]When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in select states due to licensing laws. Laws differ by state. If you have an HSA-qualified deductible plan, you may need to pay the full charges for scheduled phone appointments and video visits until you reach your deductible. Once you reach your deductible, you won't pay anything for scheduled phone appointments and video visits.

III. SUPPORT FOR MEMBERS

This information will help you direct your employees to the right resources. Employees can also refer to their Kaiser Permanente physician directory or visit **kp.org/doctor** for provider contact information.

A. Locations and member contact information

Locations	Selecting or changing a primary care physician	Emergencies
To find the nearest Kaiser Permanente medical centers, visit **kp.org/facilities**. A map of Kaiser Permanente locations can be found on the next page.	Choose or change your physician at **kp.org/doctor**. Or call **800-777-7902** (TTY **711**), 24 hours a day, 7 days a week.	If you think you're experiencing a medical emergency, immediately call 911 or go to the nearest emergency facility anytime, day or night. Unsure if you're experiencing a medical emergency? Call **800-677-1112** (TTY **711**).
Medical advice	**Appointments**	**Behavioral heath appointments**
Talk with one of our nurses or even video chat with a doctor using your computer or mobile device.[3] For more information on our video capabilities, go to the Get Care section on page 9. Or call **800-777-7904** (TTY **711**), 24 hours a day, 7 days a week. If the doctor does not practice in a Kaiser Permanente medical center, contact the physician's office directly.	Make, change, or cancel appointments with your primary care physician or for certain specialty care by signing in to **kp.org/appointments**.[4] Or call **800-777-7904** (TTY **711**), 24 hours a day, 7 days a week. If the doctor does not practice in a Kaiser Permanente medical center, contact the physician's office directly.	Appointment staff members are available at **866-530-8778** (TTY **711**), Monday through Friday, 8:30 a.m. to 5 p.m.
Prescription refills	**Member Services**	**Claims**
Prescription refills can be ordered online at **kp.org** or by calling **800-700-1479** (TTY **711**), 24 hours a day, 7 days a week.[5]	For non-urgent questions or comments about your health plan, visit **kp.org**, available 24 hours a day, 7 days a week. Call Member Services at **800-777-7902** (TTY **711**), Monday through Friday (except holidays), 7:30 a.m. to 9 p.m.	Go to Section E, page 14, for more information on filing claims or refer to you *Evidence of Coverage*.

[3]When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in select states due to licensing laws. Laws differ by state. If you have an HSA-qualified deductible plan, you may need to pay the full charges for scheduled phone appointments and video visits until you reach your deductible. Once you reach your deductible, you won't pay anything for scheduled phone appointments and video visits.
[4]These features are available only for care and services received at a Kaiser Permanente medical facility.
[5]Certain services offered on **kp.org** are available only for care and services received at Kaiser Permanente facilities.

B. Service area map and locations listing

To find a location near you, visit **kp.org/facilities** or download the Kaiser Permanente app for your smartphone or mobile device from the App Store℠ or from Google Play℠.[6,7]

Maryland

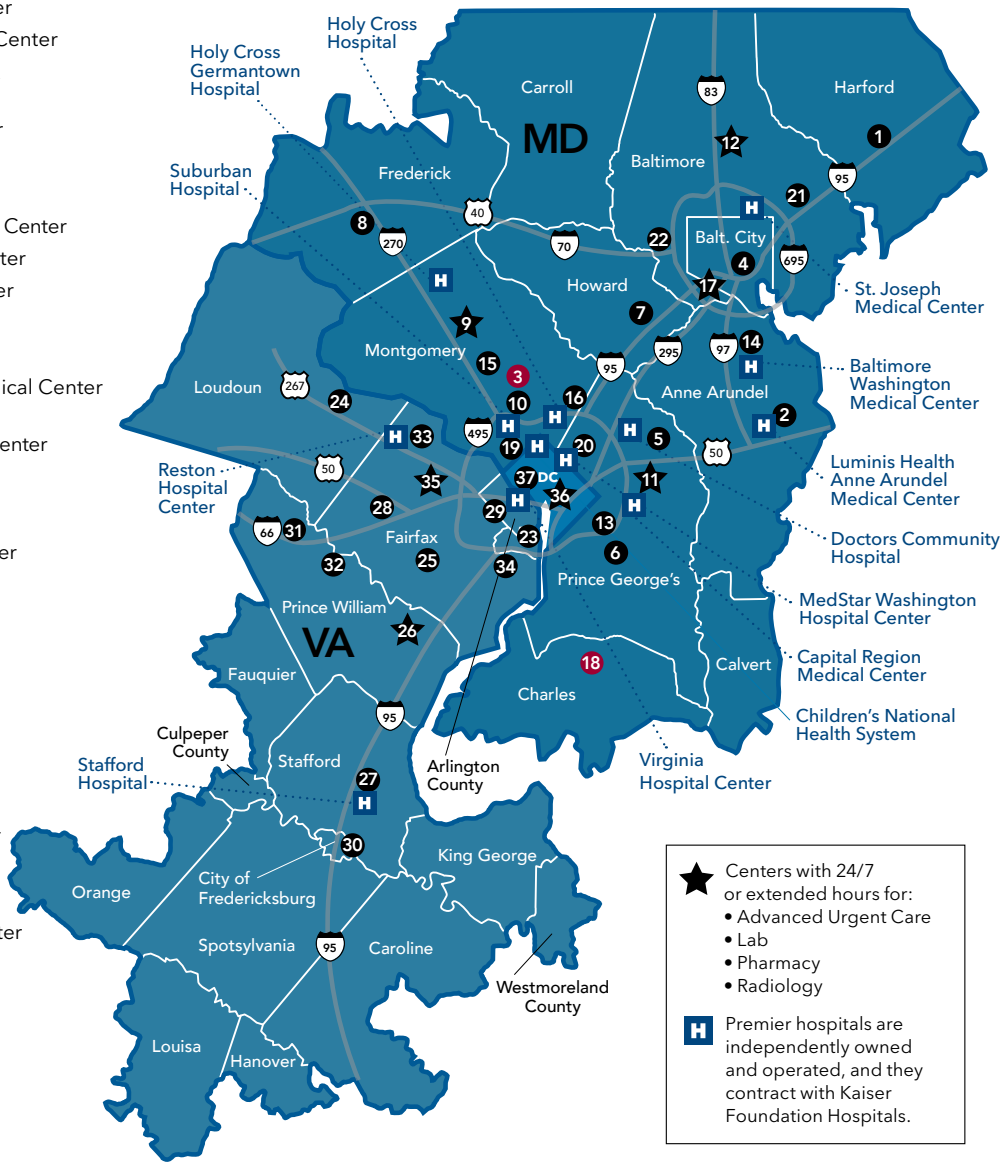
1 Abingdon Medical Center
2 Annapolis Medical Center
3 **FUTURE LOCATION**
Medical Center in Aspen Hill
4 Kaiser Permanente Baltimore Harbor Medical Center
5 Bowie Fairwood Medical Center
6 Camp Springs Medical Center
7 Columbia Gateway Medical Center
8 Kaiser Permanente Frederick Medical Center
9 Gaithersburg Medical Center
10 Kensington Medical Center
11 Largo Medical Center
12 Lutherville-Timonium Medical Center
13 Marlow Heights Medical Center
14 North Arundel Medical Center
15 Shady Grove Medical Center
16 Silver Spring Medical Center
17 South Baltimore County Medical Center
18 **FUTURE LOCATION**
Southern Maryland Medical Center
19 well Friendship Heights by KAISER PERMANENTE
20 West Hyattsville Medical Center
21 White Marsh Medical Center
22 Woodlawn Medical Center

Virginia

23 Alexandria Medical Center
24 Ashburn Medical Center
25 Burke Medical Center
26 Caton Hill Medical Center
27 Colonial Forge Medical Center
28 Fair Oaks Medical Center
29 Falls Church Medical Center
30 Fredericksburg Medical Center
31 Haymarket Crossroads Medical Center
32 Manassas Medical Center
33 Reston Medical Center
34 Springfield Medical Center
35 Tysons Corner Medical Center

Washington, DC

36 Kaiser Permanente Capitol Hill Medical Center
37 Northwest DC Medical Office Building



For the most current listing of available facilities and services, please visit **kp.org/facilities**.

Kaiser Permanente's service area in Fauquier County includes the following ZIP codes: 20115, 20116, 20117, 20119, 20128, 20137, 20138, 20139, 20140, 20144, 20181, 20184, 20185, 20186, 20187, 20188, 20198, 22406, 22556, 22639, 22642, 22643, 22720, 22728, and 22739.

Please check **kp.org/facilities** for the most up-to-date listing of the services located at Kaiser Permanente medical centers.

[6]App Store is a service mark of Apple, Inc., and Google Play is a trademark of Google, Inc.
[7]To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on **kp.org**.

C. Materials and resources for your employees

One of our goals is to provide your employees with the information they need to more easily manage their health care. In this section, you'll find more details on the tools your employees receive and the services they can access as Kaiser Permanente members—starting with their member welcome kit.

Member guide

In their new member kit, your employees will receive a Kaiser Permanente member guide that will help them understand and use the care and coverage they receive as a Kaiser Permanente member. It puts important information at their fingertips, including details about medical centers, important phone numbers, and how to begin using their plan. They'll also find important information about referrals, pharmacies, and claims. Encourage your employees to take an active part in their health by completing these three easy steps to get started:

4. Choose a primary care doctor at **kp.org/doctor** and change anytime.
5. Register for secure access at **kp.org**, so they can make routine appointments, check most lab results, and order most prescription refills.[8]
6. Transfer prescriptions to a Kaiser Permanente pharmacy at **kp.org/facilities** or by calling **800-700-1479** (TTY **711**).

Physician directory

Members can always find the most up-to-date information on Permanente physicians, specialists, and obstetrician-gynecologists through our online physician directory at **kp.org/doctor**. While each doctor is unique, the following information for our physicians is in the online directory:

- Physician name
- Contact information
- Address of their personal web page
- Provider number
- Non-English languages spoken
- Education and training
- Gender
- Medical centers/hospitals where the physician practices
- If the physician is board-certified[9] or awaiting certification

In their member kit, your employees will also receive a physician directory request card. If they want a printed copy of our physician directory, they can fill out the request card and mail it back to us.

[8]Certain services offered on **kp.org** are available only for care and services received at Kaiser Permanente facilities.

[9]Board-certified doctors meet additional standards beyond basic licensing requirements. They demonstrate their expertise by earning board certification through one of the 24 member boards that are part of the not-for-profit American Board of Medical Specialties (ABM). Permanente physicians are board-certified or, for newly hired physicians, required to become board-certified within 5 years of hire.

Our printed physician directories[10] are updated each year, based on the plans and services we offer. The physician directory includes:

- Kaiser Permanente overview
- Lists of Permanente physicians
- Kaiser Permanente medical center locations
- Pharmacy locations
- Laboratory and radiology services
- List of Urgent Care centers and premier hospitals
- Contact information

Your employees can easily find a physician, premier hospital, or Kaiser Permanente medical center by visiting **kp.org/facilities** or contacting Member Services for help.

Digital health record

Permanente physicians have immediate access to the members' medical information so that each member gets the right care at the right time. Our physicians are connected to the largest private-sector digital health record system in the world, allowing them to:

- Consult easily with other Permanente physicians, pharmacists, nurses, and other health professionals when a member receives care at a Kaiser Permanente facility.
- Link securely to every Kaiser Permanente facility in their region, so they get coordinated care wherever they go.
- Send prescriptions to Kaiser Permanente facility pharmacies so they can be filled quickly.

Whether a member speaks with an advice nurse, sees a Permanente physician in Urgent Care at 3 a.m., or visits a specialist, their medical record gives our physicians the latest information at their fingertips.

Get care

Medical advice by phone or video[11]

Your employees can get medical advice 24/7 by phone from skilled nurses or get advice in a video chat with an emergency medicine physician, both at no cost share.[12] The physicians and nurses have access to your employees' medical information to help ensure accurate, safe, and personal advice.

Video appointments[11]

Your employees can also have a video appointment with their personal physician when coming in for a visit may not be clinically needed, at no cost share.

Medical centers, urgent care, and premier hospitals

[10]The continued availability and locations of physicians or services of any medical centers cannot be guaranteed. Addresses, telephone numbers, and hours of operation are subject to change. Not all services are available at each medical center or site. Kaiser Permanente reserves the right to relocate services.

[11]When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in select states due to licensing laws. Laws differ by state. If you have an HSA-qualified deductible plan, you may need to pay the full charges for scheduled phone appointments and video visits until you reach your deductible. Once you reach your deductible, you won't pay anything for scheduled phone appointments and video visits.

[12]Available only for care and services received at Kaiser Permanente medical facilities.

Medical centers

As Kaiser Permanente members, your employees have access to our multispecialty medical centers located in Maryland, Virginia, and Washington, DC. All Kaiser Permanente medical centers offer primary care and feature on-site pharmacies. Most medical centers also offer:

- Laboratory
- Obstetrics-gynecology
- Pediatrics
- Radiology
- Specialty care

Some centers offer:

- 24/7 urgent care
- Ambulatory surgery
- Behavioral health services
- Vision care and optical services
- And other services

Urgent care[13]

All Kaiser Permanente Urgent Care centers offer more clinical capabilities than average urgent care centers, including:

- General radiology (X-ray)
- The ability to administer IV medications on site
- Pharmacy located on site
- Urgent lab services, also on site

Our Advanced Urgent Care locations offer additional services, such as:

- 24/7 hours of operation
- Advanced imaging (CT scans or MRIs)
- Extended treatment and observation capabilities, including cardiac monitoring, blood transfusions, and more
- Physicians board-certified in emergency medicine

For more information, visit **kp.org/urgentcare/mas**.

Premier hospitals[14]

Kaiser Permanente carefully selects premier hospitals to team with us in taking great care of you. We've chosen award-winning hospitals to team with in coordinating your care when you need inpatient or outpatient hospital care. These hospitals are located throughout Maryland, Virginia, and Washington, DC.

While a patient at a premier hospital, a member's care will be guided around the clock by Permanente physicians who exclusively care for our members at that hospital. Permanente physicians are available 24/7 and work hand-in-hand with the hospital staff and doctors. They have members' medical records on hand, right in the hospital, and they keep the records up to date as a member's care progresses. With

[13]An emergency medical condition is one that, in the absence of immediate medical attention, may result in 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part. Refer to your *Evidence of Coverage, Membership Agreement*, or federal brochure *73-047* for the complete definition of emergency medical conditions. The emergency copay is waived if admitted to the hospital within 24 hours for the same condition or if admitted directly to the hospital as an inpatient.

[14]Premier hospitals are independently owned and operated hospitals, and they contract with Kaiser Foundation Hospitals. The continued availability and/or participation of any facility cannot be guaranteed. For the most current information, visit **kp.org/premierhospitals**.

Kaiser Permanente staff on-site, a member's care is coordinated within the hospital and with the member's primary care physician, ensuring the smooth transition of care before, during, and after hospitalization.

Not all hospitals can be a Kaiser Permanente premier facility. To qualify, each hospital has been carefully evaluated—and is regularly reassessed—for it's quality of care, comfort, and services. All premier hospitals are evaluated for safety and quality by independent third parties and offer top-rated, award-winning care.

Managing care on kp.org

As a Kaiser Permanente member, your employees have **kp.org** as their connection to great health and great care. Once registered, your employees can securely access many timesaving tools and resources to help them manage their health and keep them feeling great.

Members can visit **kp.org** anytime, from anywhere, to:[15]

- View most lab results.
- Refill most prescriptions.
- Email their doctor's office with nonurgent questions.
- Schedule and cancel routine in-person and video appointments.[16]
- Print vaccination records for school, sports, and camp.
- Manage a family member's health care.
- Get a personalized cost estimate.
- And much more.

Your employees can also download the **Kaiser Permanente app** to their smartphone from the App Store® or Google Play™.[17,18]

Estimates (treatment cost calculator)

Members can get cost estimates by logging into their **kp.org** account.

A member's estimate takes into consideration the member's plan benefits and how much they've spent so far on care. The estimate gives a general idea of what the member will pay, including the low, likely, and high cost of the service. What the member actually pays may be higher or lower depending on the care they receive.

If the estimate is more than the member can afford to pay, we don't want this to keep them from getting the care they need. We offer several options to help members manage their medical expenses when they get care at Kaiser Permanente medical centers. The member should call the number on the back of their Kaiser Permanente ID card for assistance.

Travel coverage

Members are covered for emergency and urgent care anywhere in the world. It's important to remember that how members get care varies depending on where they're traveling. So your employees should plan ahead and find out what emergency and other medical services are av ailable where they'll be visiting.

[15]These features are available only for care and services received at a Kaiser Permanente medical facility.
[16]When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in select states due to licensing laws. Laws differ by state. If you have an HSA-qualified deductible plan, you may need to pay the full charges for scheduled phone appointments and video visits until you reach your deductible. Once you reach your deductible, you won't pay anything for scheduled phone appointments and video visits.
[17]App Store is a service mark of Apple, Inc., and Google Play is a trademark of Google, Inc.
[18]To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on **kp.org**.

For more information on travel coverage, your employees can visit **kp.org/travel** for helpful resources to plan for their trip, and for claim forms in case a claim for reimbursement needs to be filed after their trip.

Coverage options vary by plan, so benefits may be different than what's described here. Members should also refer to their *Evidence of Coverage* for more information about getting care away from home.

Getting care outside Kaiser Permanente service areas

Outside of Kaiser Permanente service areas, your employee will only pay their copay or coinsurance if they get urgent care at the following locations—no need to file a claim later:

- Cigna Healthcare℠ PPO Network[19]
- Concentra Urgent Care
- MinuteClinic®, including pharmacies[20]
- The Little Clinic, including pharmacies

At all other locations, your employee will need to pay the full cost of care up front and submit a claim for reimbursement. For assistance, contact Member Services at **800-777-7902** (TTY **711**), Monday through Friday (except holidays), from 7:30 a.m. to 9 p.m.

Getting care as a visiting member in other Kaiser Permanente service areas

A wide range of care may be available to members at Kaiser Permanente facilities in other Kaiser Permanente service areas, which include all or parts of these states:

- California
- Colorado
- Georgia
- Hawaii
- Idaho
- Oregon
- Washington

Members can get certain covered services in these Kaiser Permanente facilities, including routine, urgent, or emergency care. Emergency care services are available at Kaiser Permanente facilities in service areas that have Kaiser Permanente hospitals. Find Kaiser Permanente locations at **kp.org/facilities**.

Covering students who will be living away from home

If a student is seen by a student health center or any other medical center for an issue that is not urgent, the plan may not cover those services. For specific information about receiving health care when outside the Kaiser Permanente service area, members should refer to their *Evidence of Coverage*.

Healthy extras

Your employees can take advantage of our wide variety of resources to help keep them informed, inspired, and feeling their best.

Health education classes at Kaiser Permanente facilities

Our Health Education Departments offer health classes and support groups at our facilities, some of which may require a fee. Course catalogs are available in our Health Education Departments. Registration is required. To register, members can call **800-444-6696** anytime, day or night. Members can also browse course listings online at **kp.org/classes**.

[19]The Cigna Healthcare℠ PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration. Cigna Healthcare is an independent company and not affiliated with Kaiser Permanente Insurance Company or Kaiser Foundation Health Plan. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with Kaiser Permanente Insurance Company and Kaiser Foundation Health Plan. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

[20]If your employees get care at a MinuteClinic®, they'll be charged the standard copay or coinsurance. If they get urgent care at a MinuteClinic within a state with Kaiser Permanente providers, they'll be asked to pay up front for services received and will need to file a claim for reimbursement.

Monthly newsletter

When a member signs up on **kp.org**, they'll automatically start getting *Partners in Health,* our monthly, email newsletter featuring health tips, member stories, and updates on facilities and services.

Online wellness programs

Our online healthy lifestyle programs create customized action plans tailored to your employees' health needs and areas of interest. They can start with a Total Health Assessment and go from there. Visit **kp.org/healthylifestyles**.

D. Member ID cards

Once a member is approved for coverage, an ID card will be ordered and should arrive in the mail in 7 to 10 business days. If the member requires immediate assistance or needs to schedule an appointment before their card arrives, please advise them to contact Member Services at **800-777-7902** (TTY **711**) in order to obtain their medical record number if needed.

Until the member ID card arrives

Your employees should keep these phone numbers handy until their member ID card arrives:

- **Member Services** is available Monday through Friday (except holidays), 7:30 a.m. to 9 p.m., at **800-777-7902** (TTY **711**).
- **Appointments and Medical Advice Line** is available 24/7 at **800-777-7904** (TTY **711**).

Once a member obtains their medical record number

Members can register at **kp.org** for an online profile. Once a profile has been created, a copy of the member's ID card is available on the Kaiser Permanente app, and it can be displayed at check-in along with a valid form of identification. (Only Kaiser Permanente members registered on **kp.org** may use the Kaiser Permanente app.)

Lost cards

Members should keep their ID card with them at all times to receive medical services. If a member loses their ID card or the card is stolen, they can request a new one by calling Member Services at **800-777-7902** (TTY **711**), Monday through Friday (except holidays), 7:30 a.m. to 9 p.m. Download the Kaiser Permanente app and sign in with your **kp.org** account to start using your digital ID card today.

Fraud

To receive covered services, the cardholder must be a current plan member. The ID card is issued to members, and only they may use it.

If a member lets someone else use their card, we have the right to keep the member's card and terminate their membership. Any services rendered to non-members will be billed to that person at non-member rates.[21]

Any group that performs an act or practice that constitutes fraud or intentional misrepresentation of fact in connection with the coverage (which depending on the circumstances might include providing false data or knowingly submitting an enrollment request for a non-qualified individual) will be subject to termination under the group contract.

[21]Letting another person use your ID card for care is considered fraud, and can result in coverage being terminated.

E. Claims administration

Members will not file claims for services if:

- They get medical care and services from network providers.
- They get an authorized referral from their network provider to see an out-of-network provider.

If a member files a claim:

- They have up to 180 days from the date they received care to submit the claim.
- Kaiser Permanente will review the claim and decide what payment or reimbursement may be owed to the member.
- Care must be medically necessary. Members should read their *Evidence of Coverage* for more information.

To request payment or reimbursement, members should ask their service provider for a statement on its stationery or letterhead with the following information:

- Name of patient
- Date of service
- Service provided (procedures performed with CPT code)
- Diagnosis with ICD code
- Amount charged for each service

The member's Kaiser Permanente ID number should be written on each page of the statement. A specific claim form is not needed.

Claims can be mailed to the following address:

Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

Kaiser Permanente will provide a response within 30 days. An Explanation of Benefits (EOB) will be provided that details what the employee needs to pay and what the health plan will pay.

If the claim is denied, it is the member's right to file an appeal if they disagree with our decision to not pay for a claim. Members should read their *Evidence of Coverage* for more information.

F. Appeals process

A member or their authorized representative may request an informal or formal appeal by contacting Member Services at **800-777-7902** (TTY **711**), Monday through Friday (except holidays), from 7:30 a.m. to 9 p.m. Representatives are available to describe to members how appeals are processed and resolved, and to help the member with filing an appeal.

Members may also sign on to their account and submit a complaint on **kp.org**.

For complete details on appeals and/or grievances, members should refer to their *Evidence of Coverage*.

G. Explanation of Benefits

The Explanation of Benefits (EOB) is a statement that is generated biweekly, when a member receives medical services. The EOB is not a bill, but summarizes the services a member recently received, and includes:[22]

- A snapshot of services, including the date and provider's name, with dollar amounts.
- Easy-to-read progress graphs that show how close a member is to reaching their out-of-pocket maximum and, if they have a deductible plan, the deductible amount. For family accounts, it will show personalized tracking for each family member.
- Frequently asked questions and definitions of common terms.
- Detailed list of claims during the month, labeled to better match a member's medical bills. If any claims were not paid in full, they will be highlighted in orange.
- Information about a member's rights, including appeals, how to get help in other languages, and other helpful resources.

When generated, EOBs will be available on each member's **kp.org** account and/or mailed to them, depending on their plan type and service received.

[22]A member's actual EOB may show different information and details, depending on the member's plan type.

IV. SUPPORT FOR EMPLOYERS

A. Your Kaiser Permanente team

Our dedicated Account Management, Small Group Onboarding, and Employer Broker Services (EBS) teams will work closely with you to ensure access to important representatives on your group account:

Account Management	Employer and Broker Services
Account Management is responsible for managing and assisting you with the following: • Renewal, contract changes, and rate sheets • Benefit inquiries • Plan changes, including mid-year benefit buydown inquiries and strategy • Employer collateral materials, including enrollment tools and plan highlights If you're considering a benefit or contract change for the next benefit year, contact your account management team about 3 to 4 months prior to the contract renewal date. The team will send your renewal at least 60 days prior to the effective date of the contract. (When your contract is renewed, you will receive a new *Group Agreement* and *Evidence of Coverage*.) Contact your account manager as indicated in your renewal packet.	In support of our journey to an effortless health plan experience, EBS is focused on removing the noise for our customers and owning issues end to end. The EBS team supports our employers and brokers by resolving service issues, particularly those that remain unresolved through standard Kaiser Permanente channels. These issues often include concerns related to: • Access to care • Benefit and claim payment concerns • Unresolved discrepancies If you have any questions, or concerns, please contact EBS: • Phone: **855-327-0507**, Monday through Friday, 9 a.m. to 5 p.m. • Email: **MAS-EBS@kp.org**

B. Online resources and activities

Manage your group coverage online with ease and convenience at **business.kp.org** where you can:

- Read and download important announcements and publications featuring the latest health care information and news.
- Reference the wide-ranging suite of health plans available for small business employers.
- Find resources to assist employees.
- Download forms, support materials, and more.

1. Online enrollment

Our online enrollment site can help you streamline administration by assisting with enrolling members and paying bills. To sign up, register on **business.kp.org** to enroll members and pay bills.

If you have questions about setting up your account, please call Web Support at **866-575-3562**.

2. Online bill payment

To sign up for online billing, click **here**.

If you have any issues or questions regarding online bill payment, refer to the name and telephone number listed on the summary page of your Group Invoice for the Mid-Atlantic group representative assigned to your account.

Protecting your information is important to us. We implement rigorous security measures to make sure that your online information remains private and secure.

Electronic eligibility reporting process

Using electronic file interchange (EFI), you can efficiently transmit your employee's eligibility information (enrollments, disenrollments, transfers, demographic changes, etc.) by SFTP (secure file transfer protocol), eliminating the need for paper enrollment forms.

Most eligibility transactions are processed within 2 business days of the receipt of an electronic eligibility file. Remaining transactions that require additional research are completed or reported back to the sender within 5 business days of the receipt of the eligibility file.

With EFI, eligibility discrepancies can be addressed more quickly and result in adjustments being processed more efficiently, improving the accuracy of invoices. The preferred file format is the national standard (ANSI X12 834), but we can also accommodate proprietary or flat file layouts.

Files can be full files (containing all membership records) or change files (containing only those records that are changing).

The process to establish these files is simple. By engaging with the Membership Analytical Team (**CSC-EFI-EM-Liaison@kp.org**) and requesting to implement a file feed, we will coordinate our internal resources and assist the external partner (Group/TPA). File specifications, or companion guides, will be created specific to the group, and directions for transmitting test and production files will be shared. Once testing is approved, the file feed will be migrated to production and monitored to ensure our members' records are updated correctly.

C. *Group Agreement* and *Evidence of Coverage*

1. *Group Agreement*

Each year when you renew, your new contract (*Group Agreement*) is attached to the member portion of the *Evidence of Coverage*.

2. *Evidence of Coverage*

An *Evidence of Coverage (EOC)* for each plan you offer is provided within your *Group Agreement*. The *EOC* describes your health coverage, including benefits, cost sharing, limitations, exclusions, dispute resolution, and how to receive care.

Members need to register first at **kp.org** and create their account. Then they can access their most recent *EOC* by visiting **kp.org/eoc**.

If you need a PDF reader, you can download one for free at **get.adobe.com/reader**.

Members who do not have access to the Internet and/or would like a printed copy of their *EOC* may request a copy by returning the postage-paid postcard they receive after their enrollment.

3. Summary of Benefits and Coverage (SBC)

In accordance with the Affordable Care Act (ACA), we provide electronic, downloadable versions of the Summary of Benefits and Coverage (SBC) documents for each of our plans at **business.kp.org**. These documents, based on the Department of Health and Human Services' required format, summarize important information about each plan health plan option, so you and your employees can easily compare Kaiser Permanente benefits and coverage with those of other carriers.

ACA regulations require you to provide SBCs to participants and beneficiaries for the plans that you offer. (Generally, participants are employees, and beneficiaries are dependents.) You may provide SBCs to employees only, unless a dependent's last known address differs from the employee's. You can provide SBCs in either paper or electronic format. If you provide the SBCs electronically, you must comply with the SBC regulations and guidance for providing SBCs electronically. For more information, visit **dol.gov/ebsa/healthreform**, which has a list of SBC requirements and answers to frequently asked questions about SBCs.

The scenarios and time frames for providing SBCs are listed in the table below:

Event	Description	Time frame for providing SBCs
Renewal	During open enrollment if employees and dependents must actively elect to maintain coverage or if they have the opportunity to change coverage. If the person is already enrolled in a plan, the law requires you to provide an SBC only for that plan.	• For groups without a defined Open Enrollment period, SBCs should be distributed no later than 30 calendar days from the start date of the new contract. If there is a change of benefits from the SBC provided at Open Enrollment, the updated SBC must be provided no later than the start date of the new contract. • No later than 7 business days after we issue the *Group Agreement* or receive written confirmation of the group's intent to renew (whichever is earlier). If renewal is automatic and we have not issued the *Group Agreement* (or otherwise renewed) more than 30 days before the first day of the new plan year.
Newly eligible employee	When an employee is first eligible to enroll.	• The employee can reach out to the employer 60 days prior to renewal. • Employers must include the SBC with any written application materials (no later than the first day on which the employee is eligible if there are no written application materials required). By the first day of coverage (if there are SBC changes from the original SBC provided). • Employer can access the SBC at business.kp.org.
Special enrollment	When someone enrolls as a HIPAA special enrollee (due to a qualifying event).	Employer to provide within 90 days of enrollment. SBCs must be provided no later than 7 business days from receiving the request.
Request	If an eligible employee or dependent requests an SBC or summary information about the coverage.	Employer to provide no later than 7 business days after you receive the request.
Material modification (off-cycle plan change)	For any material modification that would change the SBC previously provided and is not a part of a renewal/ reissuance. Material modications are changes that an average enrollee would consider important.	Employer must provide notice to employees no less than 60 days before the date the change becomes effective.

D. Plan information

Kaiser Permanente offers a variety of plans to meet the needs of both your company and your employees. If your company is growing, you may want to consider offering more than one plan with our multiple plan options. For more information, contact your broker or account representative.

1. Essential Health Benefits (EHBs)

Starting with plan years beginning on or after January 1, 2014, the Affordable Care Act (ACA) requires nongrandfathered small group commercial plans to cover 10 categories of essential health benefits, as defined by ACA regulations:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

2. 'Metal' tiers of coverage

Plans fit into four main categories of coverage, known as 'metal' tiers. Each tier has a different actuarial value—the percentage that the health plan will pay for covered essential health benefits based on the claims of a standard population:[23]

- Platinum: 90% actuarial value
- Gold: 80% actuarial value
- Silver: 70% actuarial value
- Bronze: 60% actuarial value

These four categories offer different levels of copayments, coinsurance, and deductibles. For example, bronze plans have lower premiums with higher out-of-pocket costs, while other metal tier plans have higher premiums and lower out-of-pocket costs.

As of 2023, the minimum range has been reduced, imposing the following actuarial value ranges for two metal-level plans:

- Bronze: 58-62% (Expanded Bronze can be as high as 65%)
- Silver: 68-72%

E. Health Care Reform Preventive Services Package

Under the Affordable Care Act, all of our small group plans cover certain preventive services with no cost sharing.[24] To view a list of the preventive services covered by Kaiser Permanente commercial health plans, visit **kp.org/prevention**.

The required preventive services are based on recommendations by the U.S. Preventive Services Task Force, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention.

[23]Source: www.healthinsurance.org/glossary/metal-plans
[24]The ACA allows a difference of +/- two points for actuarial value percentage.

V. GROUP ELIGIBILITY

A. Eligible employer groups

To be eligible to renew small group health coverage from Kaiser Permanente, the employer must meet the definition of a small employer as defined under federal and state law.

During the preceding calendar year, the employer must have employed:

- **Virginia:** An average of at least one but not more than 50 full-time equivalent (FTE) employees and must employ at least one but not more than 50 FTEs on the first day of the plan year. A valid, common law employer/employee relationship must exist.
- **Maryland:** An average of at least two but not more than 50 full-time equivalent (FTE) employees and must employ at least one but not more than 50 FTEs on the first day of the plan year. A valid, common law employer/employee relationship must exist.

Additional employer eligibility requirements other than those listed in this guide may apply. For a full list of requirements, please refer to your *Group Agreement*.

Requirements for small group coverage

- The employer must have a federal employer identification number (EIN).
- The employer must have eligible employees who live or work within the service area of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
- The employer must maintain a physical location, for business purposes, within the service area of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
- An eligible employer group is required to extend coverage to all eligible employees. New-hire coverage waiting period may not exceed beyond 90 days for those working. Employers are allotted a one-month maximum for employment-based orientation for new hires.
- An employer/employee relationship must exist, and employees must be represented on the payroll as receiving a taxable wage or commission.
- Coverage for the group cannot exclude a class of employee. The only exception is groups with union employees covered by a union-negotiated Taft-Hartley contract.
- The company must provide, if requested, a valid/current license to do business in the state in which they are applying for coverage.
- Employer groups located in Maryland or Virginia may purchase coverage directly from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., or through their state marketplace.

B. Ineligible employer groups

Groups not considered eligible for small group coverage, include, but are not limited to the following:

- A group that employs 51 or more full-time equivalent employees (Groups with 51 or more full-time equivalent employees can purchase health coverage in the large group market)
- In Maryland, a group that has a single owner with no employees and sole proprietor or partnership with no employees or any group that employs 51 or more full-time equivalent employees
- A group not located or maintaining a physical presence in Kaiser Permanente's service area, including groups that only have a P.O. box address
- Dormant or inactive companies (i.e., a group that does not maintain an active business license to conduct business within Kaiser Permanente's service area)
- A group comprised of members as opposed to employees
- A group engaged only in a seasonal business that does not span a minimum of three contiguous seasonal periods within an acceptable 12-month period

- A group formed for the express purpose of purchasing health insurance coverage
- A group that generates only rental income unless ancillary services are provided to multiple units and the group has at least one common-law employee eligible to enroll in small group coverage

C. Employer contribution

- **Maryland:** In accordance with Maryland law, carriers, including Kaiser Permanente, cannot impose a minimum contribution requirement on small groups.
- **Virginia:** A small group is required to contribute a minimum of 50% towards the total premium cost of the employee-only premium or 50% of the total cost of the employee-only premium for the lowest priced product option sponsored by the employer group.

D. Employer participation requirements

- **Maryland:** 50% minimum participation requirement
- **Virginia:** 50% minimum participation requirement

Minimum participation and employer contribution requirements are waived for small employers that apply during the annual open enrollment period from November 15 through December 15 each year. This annual open enrollment period applies to small employers that apply through the Small Business Health Options Program (SHOP) or directly through a carrier and are reserved exclusively for January 1 coverage effective dates.

VI. MEMBER ENROLLMENT AND ELIGIBILITY

A. Employee eligibility

Additional guidelines may apply. Please refer to your *Group Agreement* and *Evidence of Coverage* for more information. An employee may only select products offered by the group.

Full-time employees

To be eligible as a full-time employee, a person is required to:

- Be a permanent employee who is not a spouse or legal domestic partner of a sole proprietor owner
- Be a partner or owner who is actively engaged and regularly scheduled on a full-time basis in the conduct of the business of the small employer
- Be a person with a normal workweek averaging 30 hours, through the small employer's regular places of business
- Be subject to withholding on a W-2 form
- Have met their waiting period, if applicable

Part-time employees

- Employers can choose to offer coverage to employees who work at least 20 hours a week in Virginia and 17.5 hours per week in Maryland.
- To be eligible as a part-time employee, a person must be an active, permanent employee who is actively engaged in the conduct of the business of the small employer, and not more than 29 hours per a normal workweek, at the small employer's regular places of business.
- An employer is not required to offer coverage to part-time employees, but can do so, provided that eligibility requirements are met. If coverage is offered to one or more part-time employees, then coverage must be offered to all part-time employees working at least 20 or more hours per week.

B. Minimum age

All subscribers, with the exception of an emancipated minor, must be 18 years old as of the group's contract effective date.

Active full-time employed emancipated minors are eligible to enroll as subscribers. If any dispute arises concerning the viability of emancipation, Kaiser Permanente reserves the right to request and secure a copy of an emancipation order for the purposes of proving eligibility for coverage subscription.

C. Dependent eligibility

Dependent coverage is available to the following individuals if the employer group allows enrollment of dependents:

- Legal spouse. Spouse includes legal domestic partners who meet the employer group's eligibility requirements for domestic partnerships.
- An employee's or a spouse's children (including adopted children or children placed for adoption) who are under age 26.
- Children under age 26 for whom the employee or spouse is the court-appointed guardian.

- Disabled dependents who meet dependent eligibility rules and satisfy incapacity and financial reliance requirements to be certified as disabled dependents under the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., policy and applicable state legal requirements. The age limit does not apply to disabled dependents.

An individual is not permitted to be covered as both an employee and a dependent under the same employer-sponsored plan, nor may a child, eligible for coverage through both parents, be covered as a dependent under both parents under the same plan. Dependents may enroll only in products selected by the employee-subscriber.

Divorced/former spouses may not remain on a subscriber's contract. In addition, to be eligible as a subscriber, except as required by federal or state continuation of coverage laws, a divorced/former spouse must be employed by the same group and meet both employment and coverage election eligibility requirements.

Dependents may only enroll in products selected by the employee-subscriber.

D. Coverage for overage disabled dependent children

Dependent children can stay on a group plan until they reach age 26 (or higher if permitted by the employer group). Once they turn 26 (or higher if permitted by the employer group), the dependent child becomes "overage." If disabled, overage dependent children may remain on the plan if they meet the eligibility requirements for disabled dependents. Additional information and details on how to continue coverage for overage disabled dependents can be found in your *Evidence of Coverage*. You can also contact Member Services at **800-777-7902** (TTY **711**), Monday through Friday (except holidays), 7:30 a.m. to 9 p.m.

E. Open enrollment period

During open enrollment, you may:

- Offer health coverage to employees who did not elect coverage when they became eligible.
- Change the plans available to your employees.

During open enrollment, your employees may:

- Add or remove dependents.
- Change from one plan to another, if you offer multiple plan options.
- Waive coverage.

Your annual open enrollment period will occur each year at least 30 days prior to the first day of your contract year.

Kaiser Permanente will email or mail you a renewal packet at least 60 days before your contract effective date. The packet will contain information on what you need to do to renew coverage.

For more information on open enrollment and options for you and your employees, contact your account manager as noted in your renewal packet.

F. Special enrollment periods

There are circumstances during the year in which employees, other than new hires, and/or new dependents become eligible for coverage through a special enrollment. If an employee or dependent becomes eligible for a special enrollment, they must be added to the plan within the specified timelines in the *Evidence of Coverage*. For more information on special enrollments, please refer to your *Evidence of Coverage*.

A special enrollment may occur for any of the following reasons, including, but not limited to:

- Increase in an employee's hours so that they newly meet eligibility requirements
- Marriage, or addition of domestic partner, if applicable
- New birth
- Adoption
- Involuntary loss of other coverage

Please refer to your *Evidence of Coverage* for more information on coverage effective dates for employees and/or dependents who enroll during a special enrollment period.

VII. GROUP CHANGES

A. Address change

To change your company mailing address, contact your account manager as noted in your renewal packet.

B. Contact information change

You can change billing information or interested party changes through our online bill pay site.

C. Broker change

If you need to make a change to your group's Broker of Record (BOR), General Administrator (GA) of Record, or Third-Party Administrator (TPA), please download the BOR Authorization Form at **business.kp.org**. The letter must be dated and signed by an authorized representative of the company and should include your:

- Group policy number
- Broker and agency names
- Broker's contact information (address, phone number, and email)

Please submit the BOR letter to your account manager, or you may email the letter to the Kaiser Permanente Broker Shared Service Center at **BrokerSupport-MAS@kp.org**.

VIII. GROUP BILLING AND PAYMENTS

A. Invoicing

1. When to expect your invoice

Invoices are generated approximately 3 weeks in advance of the coverage effective date.

2. When submitted changes are reflected

Your invoice will be most up-to-date and accurate when changes are submitted before the first of each month.

Most customary changes received by Kaiser Permanente by the first of the month will be reflected on your current invoice. Changes received after the second Saturday of the month will be reflected on the following month's billing invoice.

Extensive changes received by Kaiser Permanente might not be processed all at once for that month. Transactions not processed by that time will be reflected on the following month's invoice.

3. Reviewing your invoice

As you might have changes that affect your payment from month to month,[25] it is essential that employers review each invoice thoroughly to ensure:

- The level of coverage is accurate.
- Terminations and additions of subscribers are accurately reflected.
- The monthly rate is accurate for each account listed.

If there are changes for the current month, these will be reflected on the next billing cycle invoice. Please pay according to the invoice.

For groups that have elected to be billed based on the composite premium equivalent rating methodology, premiums will not change from month to month during the contract year, regardless of employee or dependent additions or terminations.

4. Questions?

If you have questions after reading your billing information, email Commercial Membership Services at **Commercial-Membership-MOC@kp.org**.

B. Payment

Your payment should be received by Kaiser Permanente no later than the first day of the month for which coverage is requested, unless you have made other arrangements for payment. If payment is not received by the first day of the month, your account is considered delinquent. If your payment is not received within the grace period of the due date, your coverage can be terminated. The grace period is 31 days in both Maryland and Virginia. Please refer to your *Group Agreement* and *Evidence of Coverage* for complete details.

1. By check

Return the remittance copy of your invoice with a check for the amount due. Be sure to make a copy of the invoice for your records. Send your payment to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P.O. Box 741562
Los Angeles, CA 90074-1562

Note: Send only the invoice portion, your payment, and payment support documentation. Send your group name and number on your payment. No other information should be mailed with your payment.

[25]For groups that have elected to be billed based on the composite premium equivalent rating methodology, premiums will not change from month to month during the contract year, regardless of employee or dependent additions or terminations.

2. Allocating payments

Your invoice will include a remittance advice sheet that you can use to let us know how you would like to allocate payments.

3. Nonpayment

Kaiser Permanente is a prepaid health plan; premiums are due the first day of the month. In the event payment is not received within the grace period outlined above, and in your *Group Agreement* and *Evidence of Coverage,* coverage for all members under your group plan (including employees and dependents) may be terminated due to nonpayment of premium.

IX. EMPLOYEE AND DEPENDENT CHANGES AND TERMINATIONS

A. Adding employee and dependent information

Employees and/or dependents can be added for coverage through our online enrollment site at **business.kp.org**. You must be registered in order to make any changes.

Be sure to specify the exact date of eligibility, based on your group's eligibility guidelines, when submitting enrollment changes.

B. Updating employee and dependent information

To update employee or dependent information, such as name, address, or phone number, employers can submit changes through our online enrollment site at **business.kp.org**.

C. Terminating employee coverage

Employers are required to report a termination for any employee who becomes ineligible for coverage. To terminate an employee's coverage, submit the changes through our online enrollment site at **business.kp.org**.

Members will be terminated as of the date the termination request is received by Kaiser Permanente Employer Services. All rights to benefits end at 11:59 p.m. on the termination effective date, unless your *Group Agreement* and *Evidence of Coverage* specifies otherwise. When an employee's coverage is terminated, the entire family account is terminated, including coverage for any dependents. Depending on the reason for termination, the employee and dependent(s) may be eligible for other health coverage, such as:

- Kaiser Permanente for Individuals and Families plans
- COBRA continuation coverage
- State COBRA continuation coverage

1. Retroactive terminations (with a date in the past)

According to the Affordable Care Act (ACA), retroactive terminations can only occur under certain circumstances.

Employers cannot terminate an employee's coverage (and any covered dependents) with a date in the past if:

- The employee was covered as a result of the employer's error, and
- The employee paid their premium or contributed to the cost of the health plan.

In these cases, the employee's coverage (and any covered dependents) can only be terminated with a future effective termination date.

Employers may request to terminate coverage retroactively (with a date in the past):

- As part of a monthly eligibility reconciliation, only if the employee did not pay any premium or contribute to the cost of the health plan.
- If the employee or enrolled dependents committed fraud or intentional misrepresentation

For more information, please contact your broker or Kaiser Permanente account manager.

2. Certificates of creditable coverage

Certificates of creditable coverage are currently issued to terminated Kaiser Permanente members in the Mid-Atlantic States region. The certificate documents health coverage during Kaiser Permanente membership and is the primary means individuals use to prove prior creditable coverage when seeking new group coverage.

Certificates are mailed to the member's home address shortly after their termination date.

Members with an active membership status are also entitled to receive a certificate of credible coverage within a reasonable time following submission of their request to Member Services. For more information, contact Member Services at **800-777-7902** (TTY **711**), Monday through Friday (except holidays), from 7:30 a.m. to 9 p.m.

X. GROUP TERMINATION

You can terminate your group coverage for any reason. In Maryland, you must provide 30 days advance notice and in Virginia, you must provide 31 days advance notice. Please refer to your *Group Agreement/Evidence of Coverage* for more information. A voluntary termination cannot override an administrative termination.

A. Requesting termination (voluntary)

You may request termination of your employer group policy by contacting your assigned account manager as noted on your renewal packet.

B. Administrative termination

We may terminate or non-renew your coverage as permitted by law for any of the following reasons, including but not limited to:

- Fraud or intentionally furnishing incorrect or incomplete information,
- Nonpayment of premium,
- There are no longer subscribers who live or work in the Kaiser Permanente service area, and/or
- Failure to meet minimum contribution, or participation requirements.

All rights to benefits/covered services under your *Group Agreement/Evidence of Coverage* end at 11:59 p.m. on the termination date.

C. Re-instatement and re-enrollment rules

If your contract has been terminated or non-renewed, you may request re-instatement or re-enrollment, depending on when your coverage ended.

If your coverage was terminated or non-renewed less than 60 days before a request, your group coverage may be re-instated.

When your contract is re-instated, the re-instatement is retroactive, going back to the termination date as though your group's contract had never terminated, and:

- You will keep your prior customer ID (CID) account number.
- Your group's effective date will be the same date as prior to termination.
- You are responsible for all premiums retroactive to the termination date.

Re-instatement requests for terminations because of nonpayment must be submitted to Employer Broker Services at **Commercial-Membership-MOC@kp.org**. All other reinstatement requests must be emailed to your account manager as noted in the renewal packet.

If your contract has been terminated or non-renewed for more than 60 days before a request for coverage, you may re-apply for coverage with Kaiser Permanente if your group satisfies the requirements for coverage. You will be treated as a new customer and all new customer policies will apply.

Groups that were previously terminated for non-payment and wish to return to Kaiser Permanente will still be responsible for paying any outstanding premiums. If prior balances are not paid, legal action, such as referral to collections, may be taken.

XI. COVERAGE OPTIONS FOLLOWING CONTRACT TERMINATION

If your group coverage is terminated, you and your employees have alternative coverage options, including but not limited to the options listed in this guide. For complete details on alternate coverage options, please refer to your *Evidence of Coverage*.

A. Extension of benefits

In those instances when a member's coverage with Kaiser Permanente has terminated, we will extend benefits for covered services in certain situations, including total disability, for a specified period of time. For more information and details on these situations, please have your employees refer to their *Evidence of Coverage*.

B. Continuation of group coverage

Under special circumstances, members may request to receive continued health care services from their provider for a specified period of time, as indicated in their *Evidence of Coverage*. For more information, please have your employees refer to their *Evidence of Coverage*.

C. Federal COBRA

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 the employer would otherwise terminate.

Participation in the employee's health plan, as well as coverage under whatever medical programs are provided by the employer to employees and their dependents, may be continued under COBRA for groups that employed 20 or more employees for at least 50 percent of the previous year.

- The employer is responsible for administration (within the guidelines established by the federal government for compliance by employer groups).
- Kaiser Permanente does not offer federal COBRA administration support.

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 either the employer or a third-party administrator appointed by the employer. Kaiser Permanente 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 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.

Detailed information about COBRA is available on the U.S. Department of Labor website at **dol.gov**.

1. Monthly billing of your COBRA members

You (or your designee) can bill and collect the premiums for all your COBRA members. If so, you (or your third-party administrator) will pay Kaiser Permanente for all your COBRA members as a group, just as you do for your active employees. Do not send Kaiser Permanente individual payments for each COBRA member.

2. How to enroll COBRA members

When an employee or dependent chooses Kaiser Permanente COBRA coverage, they must complete a Kaiser Permanente enrollment and change form, which they must submit directly to the group. You will then submit the enrollment and change form and report any terminations the same way you would usually report membership changes. We will not accept any enrollment and change forms directly from your employees.

Kaiser Permanente will accept enrollment only for the minimum and maximum time frames considered permissible as specified under COBRA regulations. Members who intend to elect and pay for COBRA coverage may use Kaiser Permanente services during the interim between their termination from health coverage and their enrollment into COBRA. You should make them aware of the following:

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

3. Employee notification

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

4. Termination of employer contract

A COBRA enrollment unit is attached to the active *Group Agreement*. If the *Group Agreement* for the active group is terminated, the COBRA enrollment unit will be considered terminated as well. Terminated COBRA participants may be offered the opportunity to convert to one of our Kaiser Permanente for Individuals and Families plan.

5. Open enrollment changes

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

D. ERISA status

On July 23, 2010, the Departments of Labor, Treasury, and Health and Human Services issued interim final regulations regarding claims and appeals procedures for group health plans to implement the requirements of the federal health care reform legislation. As part of Kaiser Permanente's efforts to answer federal and state regulatory inquiries regarding member's claims and appeals related to the new requirements, a group's Employee Retirement Income Security Act (ERISA) status must be verified. To ensure compliance, employer groups are asked to initially indicate their ERISA status on the Small Group Application and then annually with the renewal notice to update Kaiser Permanente if the reported status is no longer valid.

The federal Employee Retirement Income Security Act sets minimum standards for employee retirement and benefit plans established by private employers and employee organizations. While ERISA doesn't require that employers or unions offer any retirement or benefit plan, it does require that those who do establish plans meet certain standards.

ERISA covers retirement as well as health and other welfare benefit plans, such as those providing life insurance, disability coverage, and flexible spending accounts for health care expenses. Among other things, ERISA requires that individuals who manage retirement and benefit plans meet certain standards of conduct as fiduciaries. ERISA also imposes detailed requirements for reporting to the federal government and disclosure to participants, as well as assuring that plan funds are protected and that only qualified plan participants receive their benefits.

The Employee Benefits Security Administration website (**dol.gov/ebsa/**) has information that will help employers and employee benefit plan representatives understand and comply with ERISA requirements for administration of their health and welfare plans. Although paying for employee health care coverage means an employer has established a group health plan, the following types of group health plans are generally not subject to ERISA:

- Government plans
- Church plans
- Plans maintained solely for complying with applicable workers' compensation laws or unemployment compensation or disability insurance laws
- Plans maintained outside the U.S. primarily for the benefit of nonresident aliens
- Unfunded excess benefit plans

If a client is unsure of their group health plan's ERISA status, it is recommended that they consult a financial or legal adviser.

E. Federal TEFRA and DEFRA

Legislation was enacted to regulate employee health coverage. Based on this legislation and the limitations of the Kaiser Permanente agreement, if a business employs on average fewer than 20 employees in a year, and any employee turns 65, then their primary health carrier must be Medicare. For these employees who are 65 years old and choose to retain their Kaiser Permanente small group coverage, Kaiser Permanente will apply contract benefits as a secondary carrier for Medicare benefits paid or payable. This applies whether or not the employee has applied for and has been made effective for Medicare Part A and B coverage.

When a member is covered by both Medicare as primary and a Kaiser Permanente contract as secondary, total benefits provided by Medicare and Kaiser Permanente should equal but not exceed the benefits of group members who do not have Medicare coverage.

Kaiser Foundation Health Plan is secondary to Medicare when any of the following is met:

- The employer has fewer than 20 employees, and the subscriber is age 65.
- Subscribers under 65 are eligible for Medicare due to a disability.
- Subscribers are enrolled following the first 30 months of kidney dialysis treatments for end-stage renal disease (ESRD).

F. State COBRA

Under state COBRA law (also known as "mini-COBRA"), groups with less than 20 employees must provide continuation of group health coverage to employees and their covered dependents when their group health coverage with the employer would otherwise terminate. "Mini-COBRA" laws vary by jurisdiction.

Maryland: An employee and/or their dependents are eligible for up to 18 months of continuing coverage under Maryland state law. The employer must provide notice to the employee outlining the employee's options for continuing coverage. The employee must elect coverage within 45 days after the date that coverage would otherwise terminate, and they are responsible for paying all health coverage premiums required to obtain and maintain coverage during the eligible coverage period.

Virginia: An employee and/or their dependents are eligible for up to 12 months of continuing coverage under Virginia state law. The employer must provide notice to the employee outlining the employee's options for continuing coverage within 14 days after the date that coverage would otherwise terminate. The employee has 31 days to elect coverage, and they are responsible for paying all health coverage premiums required to obtain and maintain coverage during the eligible coverage period.

Any members who call Kaiser Permanente for mini-COBRA enrollment information will be referred back to their employers.

G. Kaiser Permanente for Individuals and Families plans

Upon termination of a member's Kaiser Permanente group coverage, the member has the option to switch to a non-group plan. For eligibility and other information on our Individuals and Families plans, members can:

- Call Kaiser Permanente Member Services **800-777-7902** (TTY **711**)
- Call **800-494-5314** or visit **buykp.org/apply**
- Visit their appropriate Health Insurance Marketplace, also known as the health insurance "exchange"
  - **District of Columbia: dchealthlink.com**
  - **Maryland: marylandhealthconnection.gov**
  - **Virginia: marketplace.virginia.gov**

XII. NEW GROUP ENROLLMENT CHECKLIST

☐ Business eligibility

The employer group must have a defined physical location or employees working within the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., service area and maintain an active business license. Kaiser Permanente staff will perform internal checks via state websites to validate the legitimacy of the group.

- ☐ If status is other than Active, then customer will need to provide alternative documentation (e.g., business license, startup documents, etc.) or submit proof of valid standing.

☐ Completed group application

Complete the group application, including a dated signature of the authorized contract signer or interested party and date of the signature, *within ninety (90) days prior to the effective date*. Complete all broker and GA information.

☐ Most recent Quarterly Wage & Tax Statement, payroll records, pay stubs, W-4, letter

Groups that enroll six or more subscribers are not required to submit a Quarterly Wage & Tax Statement.[1] The Quarterly Wage & Tax Statement must be the most recent and must include a full quarter of data. Employees listed on the form must be annotated by the Group Administrator as follows:

- P/T = Part-time
- W = Waiving
- E = Enrolling
- T = Terminated
- WP = Waiting period

- ☐ Copy of the most recently issued payroll records
- ☐ Two most recent pay stubs and a W-4 form for newly-hired employees not on the Quarterly Wage & Tax Statement
- ☐ Employer letter (signed and dated) if owner is taking a draw from the company or does not appear on the Quarterly Wage & Tax Statement

☐ Quote

Include a copy of the signed final group quote.

- ☐ Composite premium rates: A 2-subscriber minimum is required in each plan for which a group is billed using composite premium-rate equivalent methodology.

☐ First month's premium

EFT form. The group will be notified when the payment is processed.
Premium checks must be mailed to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P.O. Box 64345
Baltimore, MD 21264-4345

☐ Completed Kaiser Electronic Eligibility List (KEEL) or employee enrollment forms

☐ Employee waiver forms

Employee waiver forms do not need to be submitted to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., if a KEEL was provided. Employer groups should obtain and maintain employee waivers.

[1] Kaiser Permanente reserves the right to request additional and/or satisfactory documentation to verify that a group applicant and its employees meet all eligibility criteria, and to cancel a Small Group Employer Application when such documentation is not provided.

ADDITIONAL ENROLLMENT TIPS

- ### Service area

  Confirm group has a defined physical location or employees working within the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., service area.

- ### Business eligibility verification

  Virginia Business License Information System research site:
  cis.scc.virginia.gov/EntitySearch/Index

  Maryland Business License Information System research site:
  egov.maryland.gov/BusinessExpress/EntitySearch

- ### Quarterly wage and taxes statement

  D.C. businesses:
  Form DOES - UC30_ Employer's Quarterly Contribution and Wage Report (Fillable PDF).pdf

  Maryland businesses:
  2025 Employer Withholding Forms - Taxpayer Services

  Virginia businesses:
  Employer Quarterly FC20/21 eForm

- ### Full-time equivalency

  Confirm employer group has 50 or fewer full-time equivalent (FTE) employees.
  healthcare.gov/shop-calculators-fte

- ### Participation requirements for off-exchange plans

  Virginia's minimum participation requirement is 50% for all group sizes.
  Maryland's minimum participation requirement is 50% for all group sizes.

  Minimum participation and employer contribution requirements are waived for small employers that apply during the annual open enrollment period from November 15 through December 15 each year. This annual open enrollment period applies to small employers that apply through the SHOP (Small Business Health Options Program) or directly through a carrier, and is reserved exclusively for January 1 coverage effective dates.

- ### Summary of Benefits and Coverage (SBC) for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., plans

  healthy.kp.org/maryland-virginia-washington-dc/support/forms/health-plans/small-groups-summary-benefits-coverage

- ### Prior group with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

  Groups that have canceled with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., within 6 months are not considered New Business and should be submitted to the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Account Management team.

- ### Sales quoting

  business.kp.org/business/signon

- ### Small Group Guidelines

  business.kaiserpermanente.org/business/broker/maryland-virginia-washington-dc/marketing-and-sales-materials/small-business

- ### Field sales guide

  business.kp.org/business/forms-and-documents

Policy effective date

Policy effective dates can be the 1st or 15th day of the month.

- Final rates are based on actual group enrollment for a specific policy effective date. A new rate quote may be required for a change or postponement of a policy's effective date. Rates may vary by policy effective date.
- Existing employees and their dependents (if the employer offers dependent coverage) are eligible for coverage on the employer's effective date.
- An employer group can make a plan change up to the 30th day following the group's effective date.

Submission deadlines

Coverage effective date can begin on either the 1st or the 15th day of the month. The complete group submission must be received by Kaiser Permanente by noon on the effective date.

Note: If the submission deadline falls on a Saturday, Sunday, or holiday, Kaiser Permanente will extend the submission deadline date until the next business day within that applicable month.

Questions?
See your Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., sales representative or call **866-523-0924.**

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 4000 Garden City Drive, Hyattsville, MD 20785 2025SG1177 MAS 10/31/25-12/31/26