KAISER PERMANENTE®

Employer Group Handbook

Mid-Atlantic States Region, April 2019

TABLE OF CONTENTS

INTRODUCTION

Thank you for choosing Kaiser Permanente as your health care provider. We're glad to be your partner on this journey, and look forward to providing you and your employees with integrated, high-quality care for years to come.

This handbook is designed to help you make the most of your relationship with Kaiser Permanente by putting key information within easy reach. This includes the enrollment process for members and dependents, eligibility guidelines for prospective members, ways to manage your membership status, billing and payment methods, and more. You will also find a glossary of terms and important contact information for our staff, who will be happy to provide you with more information or clarification whenever necessary.

We encourage you to read this handbook carefully and keep it on hand for easy reference, so that we can ensure your health care is intuitive and accessible.

Welcome to Kaiser Permanente.

Christine Angotti-Watts
Executive Director, Health Plan Service

Important contact information

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

Contact	Number(s)/email	For questions about	Hours of operation
Sales and Account Management Small and large groups—contact your account manager	New sales: **866-523-0924** Existing groups—please contact your account manager	• Renewals • Open enrollment planning • Product quoting and selections • Group contracting	Monday – Friday 8:30 a.m. – 5 p.m.
Employer Broker Services – formerly Client Services Unit The EBS team is a designated single point of contact to assist brokers and key personnel of contracted employer groups. EBS is dedicated to quickly resolving service inquiries, such as billing eligibility and claim disputes.	Email: mas-ebs@kp.org Number: **877-514-5114**	• Invoices and billing questions • Benefit clarifications • Enrollment • Retroactivity • Claim assistance • Access to care issues	Monday – Friday 8:30 a.m. – 5 p.m.
Member Services If your employees need assistance with or have questions about their health plan or specific benefits, they can speak with one of our Member Services representatives.	Within the Washington, DC, metro area, call **301-468-6000** (TTY **711**) Outside the Washington, DC, metro area, call **800-777-7902** (TTY **711**)	• Benefit clarification • Appeals and complaints • Obtaining forms • Member ID cards • Member-level demographic changes • Claim status	Monday – Friday 7:30 a.m. – 9 p.m.
Appointments and medical advice	Within the Washington, DC, metro area, call **703-359-7878** (TTY **711**) Outside the Washington, DC, metro area, call **800-777-7904** (TTY **711**)		24 hours a day
5500/Schedule A Team	Email: 5500-central-team@kp.org	ERISA	Monday – Friday 8:30 a.m. – 5 p.m.

Glossary of terms

5500 Form/Schedule A
The 5500, Annual Return/Report of Employee Benefit Plan, is the form used to file an employee's benefit plan annual information return with the Department of Labor.

Dependent
An individual other than the subscriber who is eligible to receive health care services under the subscriber's contract.

Family
Unit consisting of a subscriber and any eligible dependents.

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

Group enrollment/change form
The Kaiser Permanente form used for initial enrollment of subscribers/dependents and any enrollment changes made after the contract's effective date.

Health Insurance Portability and Accountability Act
Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), you are guaranteed coverage without medical review if you meet certain specific eligibility requirements and provide proof of prior creditable coverage.

Invoice
The monthly bill or statement produced to detail health care premiums.

Kaiser Electronic Eligibility Layout (KEEL)
A modified Excel spreadsheet to be used primarily by small employer groups to send member eligibility information for processing into Kaiser Permanente's membership system.

Medical record number
Individual number assigned to every member and featured prominently on their Kaiser Permanente ID Card.

Member
An individual who has been enrolled in a health plan as a subscriber or an eligible dependent of a subscriber.

Mid-Atlantic Permanente Medical Group (MAPMG)
An independent, multispecialty group of physicians that provides covered medical/health care services to members in the Mid-Atlantic States service area.

PLF/820
Electronic payment files.

Proration type
Billing option to determine how you will be charged for monthly premiums.

Service area
Kaiser Permanente's service areas include the District of Columbia; the Virginia counties of Arlington, Fairfax, King George, Prince William, Loudoun, Spotsylvania, and Stafford; the Virginia cities of Falls Church, Fairfax, Fredericksburg, Alexandria, Manassas, and Manassas Park; the City of Baltimore; the Maryland counties of Baltimore, Carroll, Harford, Anne Arundel, Howard, Montgomery, and Prince George's; and specific ZIP codes within Calvert, Charles, and Frederick County in Maryland.

Subgroup
An account created to track a group's contract. If there's more than one plan selection, the group is assigned multiple subgroups.

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

About Kaiser Permanente

Kaiser Permanente was founded in 1945 with the mission of providing convenient, connected, and personalized health care to our members and the communities we serve. Our distinct model brings together health care and plan coverage into a single system, which has made us one of America's leading health care providers and nonprofit plans. When your doctors, health plan, pharmacy, and hospitals work together, health care works better for you and your employees.

Our philosophy of care is to improve your total health by considering all aspects of wellness—mind, body, and spirit. We consider your total health both in treatment and in our preventive care practices, as maintaining health and intervening early in times of illness leads to reduced costs and better outcomes. And because we provide our members with both care and coverage, our focus is always on your health and well-being.

How we deliver care

We deliver care to our members through the collective efforts of your personal physician, specialists, and other caregivers—any of whom you may change at any time. All our staff are connected to each other and to you through our sophisticated electronic medical record system, so you always get personalized care at any location you choose to visit. We even offer a range of digital resources so you can manage your care at home, at work, or on the go. These include medical advice by phone 24/7 and video appointments* from anywhere that's convenient for you. You can also email your doctor with questions and get a reply within 48 hours or sooner, see most test results, fill most prescriptions, and more through our website and mobile app.

Our locations include an array of state-of-the-art medical centers throughout our region, each of which offers most of our services under one roof so you can cover your health needs in fewer trips. Our facilities are supported by industry-leading technology for care delivery, health promotion, disease prevention, chronic condition management, and more. We also partner with hospitals to ensure that you always have access to care, even in emergencies. And unlike insurance plans that just pay medical expenses, Kaiser Permanente provides or arranges for your medical and preventive services in our medical facilities and contracted hospitals.

Because we provide our members with both care and coverage, our focus is always on the health of you and your employees, which leads to more complete care and better outcomes.

*Video visits are available to Kaiser Permanente members who have a camera-equipped computer or mobile device and are registered at kp.org. You must be present in Maryland, Virginia, or Washington, DC, for visits with your primary care physician or mental health provider. For urgent video visits with an emergency doctor, you may also be present in West Virginia, Florida, North Carolina, or Pennsylvania. For certain medical or mental health conditions. For video visits with a mental health provider, appointments can be scheduled for follow-up care.

ENROLLMENT & ELIGIBILITY

General information

To enroll in a Kaiser Permanente plan, your employees and their dependents must meet the eligibility requirements in Kaiser Permanente's *Group Agreement, Evidence of Coverage,* Face Sheet (group-specific eligibility requirements), and any applicable amendments. New employees must enroll themselves and any eligible dependents within 31 days after becoming eligible. Eligible employees who do not enroll themselves and their dependents during this time must wait until your group's next open enrollment period to enroll.

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

- They meet your group's eligibility requirements that we have approved
- They meet subscriber or dependent eligibility requirements
- They reside or work within Kaiser Permanente's service areas at the time of enrollment

Open enrollment period

During your annual open enrollment period, all employees who did not enroll in Kaiser Permanente when initially eligible are given an opportunity to enroll themselves and their dependents. Contact your account manager to change your group's open enrollment period or effective date of coverage.

Special enrollment period (SEP)

An SEP is a time outside the yearly open enrollment period when an employee, such as a new employee, can sign up for health care coverage. An SEP can also occur for current employees due to certain qualifying life events, such as marriage, having a child, or adopting a child.

Employees who live outside the service area

All members (who have been approved) must live or work within the Kaiser Permanente of the Mid-Atlantic States service area to be eligible to enroll in the health plan. If an employee lives outside of the service area, please consult with your sales representative or account manager.

Members who move outside their service area after their initial enrollment can retain their membership. However, coverage in this situation will be limited.

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

Dependent age limit

The minimum dependent age limit is 26, unless otherwise stated by your group contract. Notice of dependent membership termination will be sent to the subscriber at least 90 days before the date coverage will end due to reaching the age limit. The dependent's membership will terminate as described in our notice unless documentation of his or her incapacity and dependency is received. If documentation has been received in the specified time and a decision has not been made before the termination date, coverage will continue until a decision is made.

Disabled dependent requirements

Your employee dependents who are unmarried and unable to sustain employment because of a developmental or physical disability may be eligible for enrollment in health coverage beyond the normal age limit (26) if all the following conditions establishing incapacitated status are met:

1. Dependent is incapable of self-sustaining employment because of a mentally or physically disabling injury, illness, or condition that occurred prior to reaching the age limit for dependents.

2. Dependent receives 50% or more of support and maintenance from the employee, or the employee's spouse, domestic partner, or legal partner.

3. Your employee submits a disabled dependent application along with documentation verifying incapacity.

Send completed application to: Kaiser Permanente
2101 E. Jefferson St.
Employer Services 5-West
Rockville, MD 20852

To send by fax: **855-414-2797**

To send by email: membership-enrollment-team@kp.org
Please allow 14 business days for review and processing.

Once the application is received, we will review and determine if the dependent is eligible as an incapacitated dependent. If your employee's dependent does not meet the guidelines above, they will be considered ineligible and coverage will be terminated. A written determination letter will be mailed to your employee.

Employees can find a disabled dependent application here.

Eligibility submission formats

Paper enrollments

Enrollment applications can be found by visiting account.kp.org/broker-employer/resources/employer.

Applications are used for new enrollment, terminations, and changes to a family member's status and/or demographic information. If completing a paper application, your employee must sign and return it to the group's human resource department.

Send completed application to:	Kaiser Permanente 2101 E. Jefferson St. Employer Services 5-West Rockville, MD 20852
To send by fax:	**855-414-2797**
To send by email:	membership-enrollment-team@kp.org Please allow three business days for review and processing.

Note: Kaiser Permanente allows 90 days to retroactively add or terminate members to a group. Applications received without a group number and signature will be returned to the sender for completion. If the application is incomplete, your employee will not be enrolled until a revised application is received.

Electronic submission formats

The Electronic Data Interchange (EDI) process provides Kaiser Permanente groups with an effective way to communicate enrollment and eligibility transactions in a secure environment. Kaiser Permanente offers multiple transmission options that are accepted within the health care industry and follow current standards for secure transfer. Your understanding and use of this handbook will ensure accurate and timely submission and will increase your satisfaction with the EDI process. 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 your personal health information (PHI). Because of this, Kaiser Permanente utilizes the 834 as our primary layout option; however, we also offer a proprietary layout (see below).

File formats

1. Electronic Data Interchange (EDI) 834 file is the preferred format.
2. Kaiser Permanente Proprietary Flat File formats are accepted on an exception basis and must be approved prior to implementation.
3. The Kaiser Electronic Eligibility Layout (KEEL) is a Kaiser Permanente Mid-Atlantic States (only) custom layout. This format consists of a Kaiser Permanente Microsoft Excel macro that has been configured to capture a set of predefined data elements. This layout is not preferred and is recommended to groups with fewer than 50 employees. The KEEL is submitted directly to membership-analytical-team@kp.org via secure email and does not undergo testing as required with the other file layouts.

File type and frequency

Kaiser Permanente allows multiple frequencies to submit your file. However, daily/weekly change files and monthly/quarterly full files are preferred. Change files should include additions and terminations of employees, spouses, and dependents; demographic changes; and subgroup changes with effective date of the subgroup change identified. If you're only sending a full file, changes should be included on the full file.

Transmission options

The Kaiser Permanente standard transmission protocol is Secure File Transfer Protocol (SFTP). If SFTP is not possible, then the Kaiser Permanente Transmission department will need to discuss alternatives with your technical contact(s). Any Secure Shell Version 2 (SSH2) protocol-compliant software may be used.

Getting started

To transmit eligibility data to Kaiser Permanente electronically, there are several steps you will need to take:

1. Notify your account manager of your intent to electronically report your eligibility.
2. Determine the effective date of your implementation.
3. Determine if you will submit your eligibility to Kaiser Permanente or if you will utilize a third-party administrator, group administrator, or broker.
4. Finalize your Kaiser Permanente group structure and subgroups.
5. Our case installation consultant will be assigned to assist you with the successful transmission of eligibility data and navigation through Kaiser.

Once Kaiser Permanente receives your Electronic Data Transfer (EDT) request, you will be asked to fill out a Trading Partner Questionnaire (TPQ). The Kaiser 834 team will work with you on developing a companion guide, documenting record layout and file specifications. This document will be forwarded to the Kaiser Permanente Information Technology (KPIT) department after the group has been set up.

Testing process

Kaiser Permanente tests all group and member enrollment electronic file formats. Testing allows the health plan to verify that files have HIPAA-compliant transaction sets and meet HIPAA requirements. During the testing process, an EDI coordinator will work with you every step of the way to ensure that your implementation is smooth. The EDI coordinator will work closely with you to identify the errors that need correcting prior to implementing your file. To have sufficient time for compliance and format testing, mapping, and implementation, Kaiser Permanente has developed the following timelines:

1. Test files must be received 14 business days prior to the effective "go live" date.
2. Production files must be received 1 week prior to the contract effective data "go live" date.
3. A cycle of testing will take 7 business days for processing.

After enrollment

Identification cards

After the health plan processes enrollment applications and files, identification (ID) cards for enrolled subscribers and their dependents are generated and mailed to the subscriber. Each enrolled family member receives his/her own card. The card itself does not entitle a member to services, nor does a member need the card to obtain services. Kaiser Permanente will only issue a new ID card for new enrollments, a change to your group's product offering, or a change to the employee's last name. Please ensure that all enrollment information is accurate upon submission to avoid sending new ID cards to members unnecessarily.

Members can call Member Services (see important contact information section of this handbook) to replace lost or damaged ID cards. Members can also access their ID cards online through the Kaiser Permanente application, which is available on both Apple and Android mobile devices.

New Member Welcome Kit

A New Member Welcome Kit will also be mailed to the subscriber upon initial enrollment. The kit will include details for your employees, including how to get care and important contact information, as well as information about Urgent Care centers, pharmacies, getting care away from home, and understanding costs.

Choosing a provider

At Kaiser Permanente, we know how important it is to find a doctor who matches each employee's specific needs. Even if an employee doesn't see his or her doctor right away, having a doctor you can connect with is an important part of taking care of your health.

To help your employees find a primary care provider (PCP) who's right for them, they can browse our online in-network doctor profiles. There, you'll see information related to our providers' education, credentials, specialties, and interest areas, as well as whether they're accepting new patients.

Change your doctor anytime

Your employees may choose and change their doctor at any time, for any reason. If they do not choose a PCP or ob-gyn within the first 30 days of enrollment, one will be assigned to them.

If the doctor that your employee would like to select is not accepting patients, the employee can call Member Services for assistance at **800-777-7904** (TTY **711**), 24 hours a day, 7 days a week.

Evidence of Coverage (EOC)

Your group's EOC documents are now available online. The EOC includes detailed descriptions of benefits, costs, exclusions, and plan guidelines. To view the EOC, employees should sign on to **kp.org** with their user ID and password, then click on the **coverage and costs** tab and go to **all coverage documents.**

BILLING

Kaiser Permanente is a prepaid health plan. Your premiums are due on the first day of each month for which coverage is requested. Failure to remit monthly dues within 31 days of your group's due date may lead to termination of all health plan coverage for your group's employees and dependents.

Billing methods

Your group may receive monthly bills from Kaiser Permanente ("paid as billed"), or your group may track your own covered members and calculate the premiums that are due ("Self-Billed"). Here are the details on each method.

Paid as billed is our preferred method of payment. If your group uses this method, you will receive a monthly invoice. When your invoice is received, any changes should be reported to our eligibility team. Pay 100% of the total amount listed as due on your invoice. Please do not alter your premium payment to account for any changes. Any adjustments that you have made to your account, such as terminations or enrollments, will be reflected in the next billing cycle.

Self-billed is a billing arrangement whereby the group reconciles covered members and premiums and remits payment, along with an 820/Paid List File billing report, to Kaiser Permanente. This should include all employees who are covered for the current month or any period in the past where payments were not submitted. (This arrangement is available to groups with a minimum of 250 eligible members.)

The 820/Paid List File must contain the following data elements:

1. Subscriber first name, subscriber last name
2. Social Security Number (SSN)
3. Group number and subgroup number(s)
4. The payment amounts

The total amount of the 820/PLF must equal the total amount of your payment.

Kaiser Permanente will base all eligibility on the report that you provide.

If your employee is not listed on the report, they will be terminated for that reporting month. A report of all discrepancies will be returned, and your group will have 10 days to respond to any discrepancies Kaiser Permanente reports

to you/the group. If your group does not reply to the discrepancies within 10 days, your group will need to resolve any credits or money that is owed in the next billing period.

Understanding your invoice

Groups that elect to receive an invoice are required to choose the paid as billed method. Generally, you will receive your invoice between the second and third weeks of each month. Changes processed prior to billing will be reflected on your current invoice. Any changes received after the billing cycle has commenced will be reflected on the following month's invoice. Timely submission of payments and enrollment data prior to the fifth of each month will help facilitate an accurate invoice. Enrollment changes and terminations should be reflected correctly on your next invoice.

If you have any questions about the billing format, Kaiser Permanente procedures, or the content of your invoice, please contact Employer Broker Services (formerly the Client Services Unit) at 877-514-5114, Monday through Friday, 8:30 a.m. to 5 p.m.

Proration rules

Full-month

If your group has full-month proration, members will be enrolled on the 1st of the month and terminated at the end of the month. A full-month premium will be charged.

Half-month

If your group has a half-month proration:

- For members enrolled between the 1st and 15th of the month, a full-month premium will be charged.
- For members enrolled between the 16th and 31st of the month, no premium will be charged.
- For members terminated between the 1st and 15th of the month, no premium will be charged.
- For members terminated between the 16th and 31st of the month, a full-month premium will be charged.

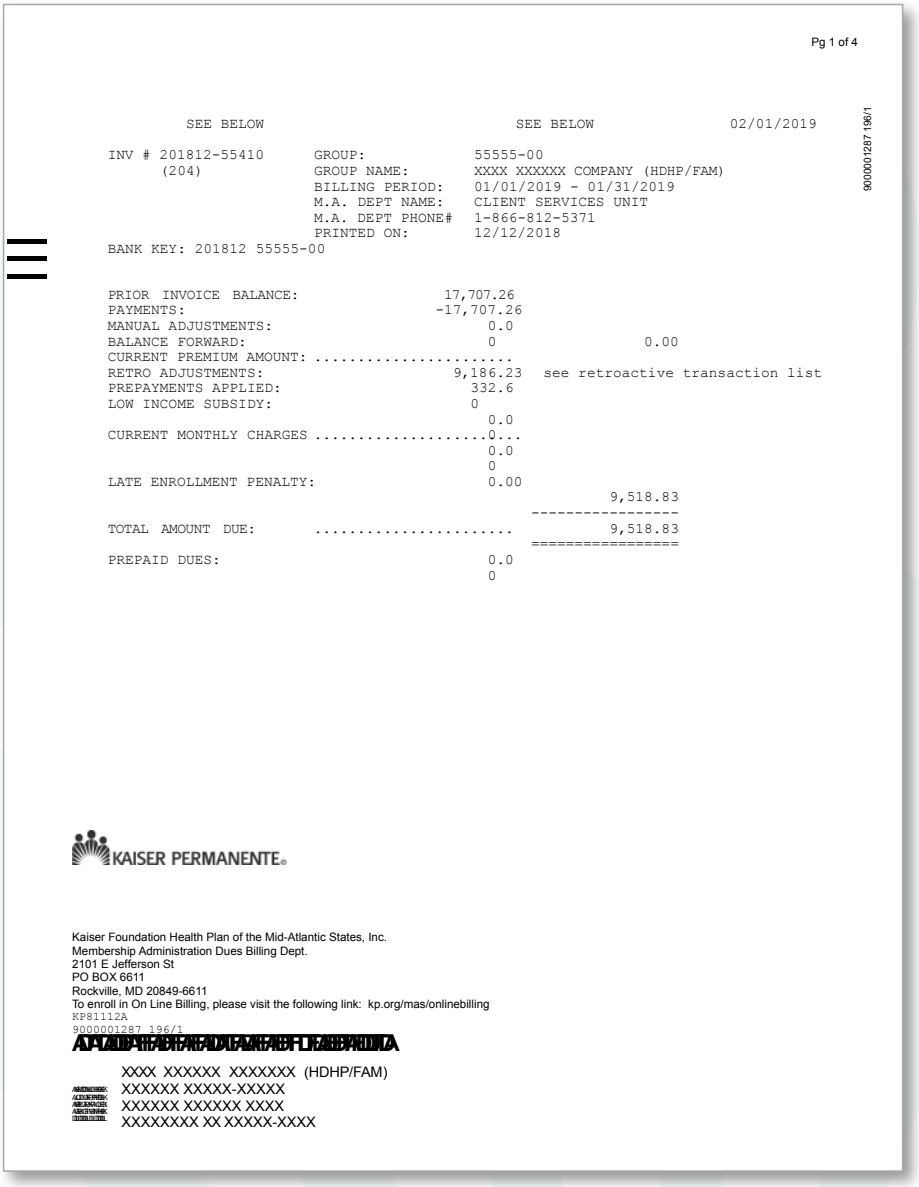
Daily

If your group has daily proration, members will be enrolled or terminated based upon the date on the file. You will be charged for the days in the month in which the member is active.

Sample billing invoice

Billing invoice – page 1

This is the first section of your invoice. It provides a summary of your balance, payments, adjustments, and total amount due.



Pg 1 of 4

9000001287 196/1

SEE BELOW SEE BELOW 02/01/2019

INV # 201812-55410 (204)
GROUP: 55555-00
GROUP NAME: XXXX XXXXXX COMPANY (HDHP/FAM)
BILLING PERIOD: 01/01/2019 - 01/31/2019
M.A. DEPT NAME: CLIENT SERVICES UNIT
M.A. DEPT PHONE# 1-866-812-5371
PRINTED ON: 12/12/2018

BANK KEY: 201812 55555-00

PRIOR INVOICE BALANCE:	17,707.26	
PAYMENTS:	-17,707.26	
MANUAL ADJUSTMENTS:	0.0	
BALANCE FORWARD:	0	0.00
CURRENT PREMIUM AMOUNT:		
RETRO ADJUSTMENTS:	9,186.23	see retroactive transaction list
PREPAYMENTS APPLIED:	332.6	
LOW INCOME SUBSIDY:	0	
	0.0	
CURRENT MONTHLY CHARGES .....0...		
	0.0	
	0	
LATE ENROLLMENT PENALTY:	0.00	
		9,518.83
TOTAL AMOUNT DUE:		9,518.83
PREPAID DUES:	0.0	
	0	

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Membership Administration Dues Billing Dept.
2101 E Jefferson St
PO BOX 6611
Rockville, MD 20849-6611
To enroll in On Line Billing, please visit the following link: kp.org/mas/onlinebilling
KP81112A
9000001287 196/1

XXXX XXXXXX XXXXXXX (HDHP/FAM)
XXXXXX XXXXX-XXXXX
XXXXXX XXXXXX XXXX
XXXXXXXX XX XXXXX-XXXX

Rate summary, subscriber listing, and adjustments – page 2

Rate summary

This section summarizes the number of subscribers in your group by subscriber type and rate.

Subscriber listing

This section lists each subscriber and a breakdown of the monthly dues for each employee.

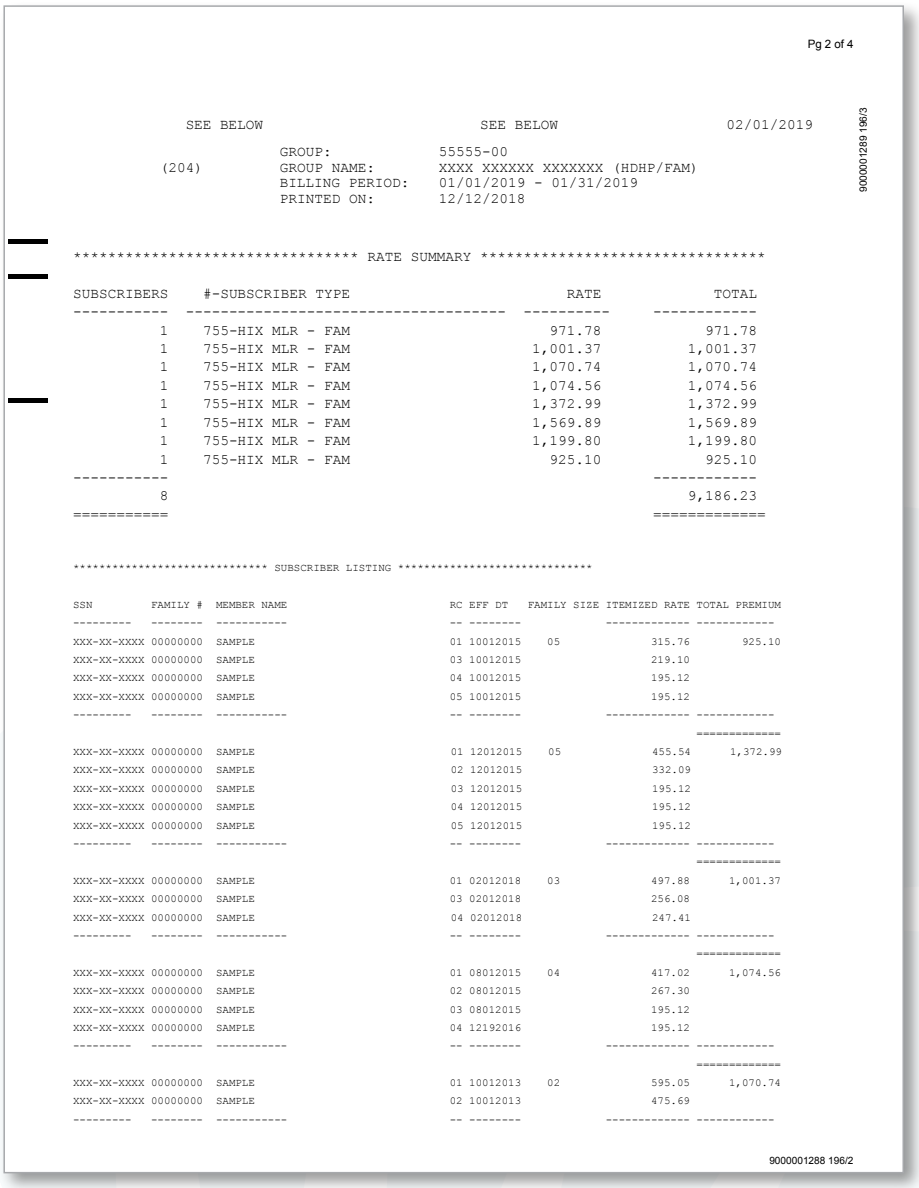
Adjustments

This section contains adjustments to your invoice.

Examples of the various types of adjustments and their abbreviations are:

- BCNR: bad check
- CCPY: credit card payment
- WIRE: wire transfer payment employer
- REIN: reinstatement
- TERM: termination
- SYER: system error
- WORE: write-off to reconciliation
- BOSC: rate adjustment
- RFTG: refund to group

This does not represent all of the adjustment codes that may appear on your invoice.



Pg 2 of 4

SEE BELOW SEE BELOW 02/01/2019

9000001289 196/3

(204) GROUP: 55555-00
GROUP NAME: XXXX XXXXXX XXXXXXX (HDHP/FAM)
BILLING PERIOD: 01/01/2019 - 01/31/2019
PRINTED ON: 12/12/2018

********** RATE SUMMARY **********

SUBSCRIBERS	#-SUBSCRIBER TYPE	RATE	TOTAL
1	755-HIX MLR - FAM	971.78	971.78
1	755-HIX MLR - FAM	1,001.37	1,001.37
1	755-HIX MLR - FAM	1,070.74	1,070.74
1	755-HIX MLR - FAM	1,074.56	1,074.56
1	755-HIX MLR - FAM	1,372.99	1,372.99
1	755-HIX MLR - FAM	1,569.89	1,569.89
1	755-HIX MLR - FAM	1,199.80	1,199.80
1	755-HIX MLR - FAM	925.10	925.10
8			9,186.23

********** SUBSCRIBER LISTING **********

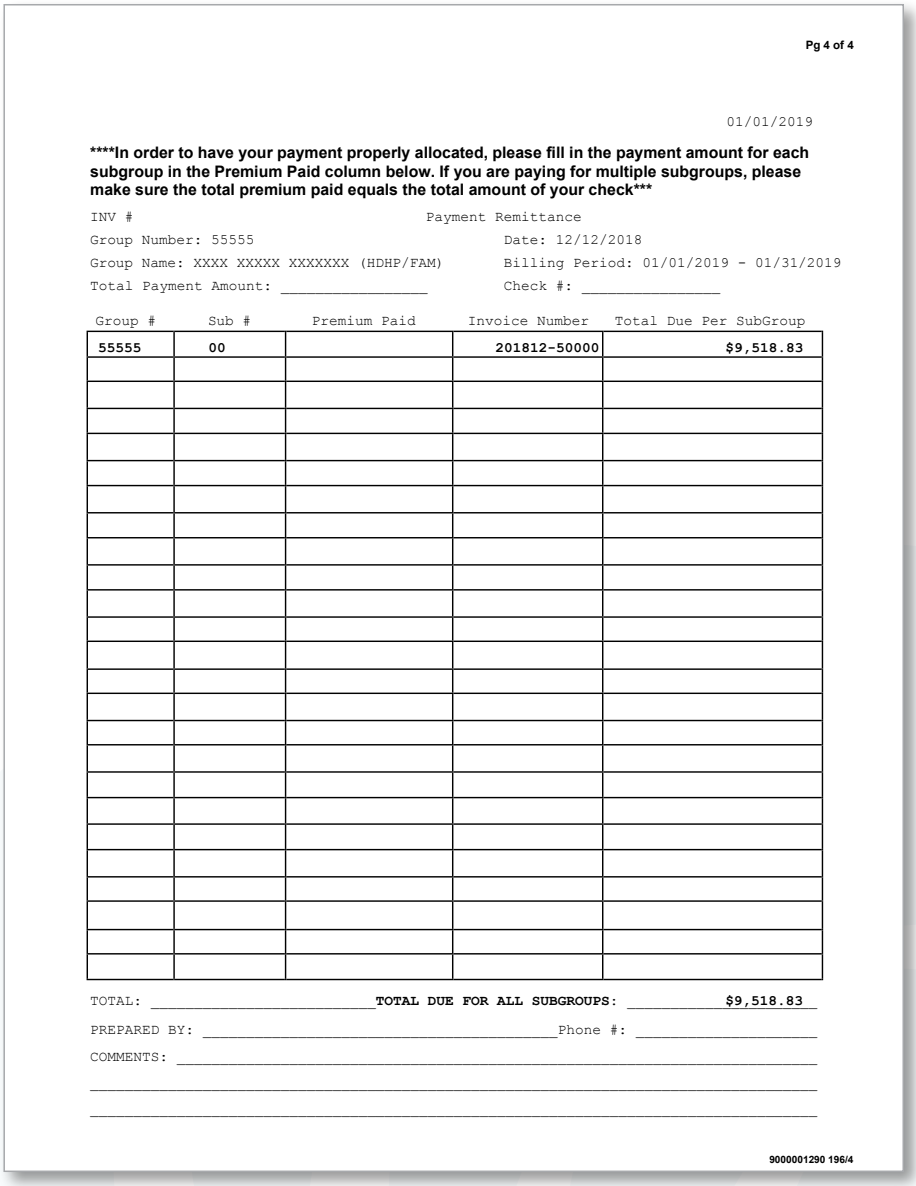
SSN	FAMILY #	MEMBER NAME	RC EFF DT	FAMILY SIZE	ITEMIZED RATE	TOTAL PREMIUM
XXX-XX-XXXX	00000000	SAMPLE	01 10012015	05	315.76	925.10
XXX-XX-XXXX	00000000	SAMPLE	03 10012015		219.10	
XXX-XX-XXXX	00000000	SAMPLE	04 10012015		195.12	
XXX-XX-XXXX	00000000	SAMPLE	05 10012015		195.12	
XXX-XX-XXXX	00000000	SAMPLE	01 12012015	05	455.54	1,372.99
XXX-XX-XXXX	00000000	SAMPLE	02 12012015		332.09	
XXX-XX-XXXX	00000000	SAMPLE	03 12012015		195.12	
XXX-XX-XXXX	00000000	SAMPLE	04 12012015		195.12	
XXX-XX-XXXX	00000000	SAMPLE	05 12012015		195.12	
XXX-XX-XXXX	00000000	SAMPLE	01 02012018	03	497.88	1,001.37
XXX-XX-XXXX	00000000	SAMPLE	03 02012018		256.08	
XXX-XX-XXXX	00000000	SAMPLE	04 02012018		247.41	
XXX-XX-XXXX	00000000	SAMPLE	01 08012015	04	417.02	1,074.56
XXX-XX-XXXX	00000000	SAMPLE	02 08012015		267.30	
XXX-XX-XXXX	00000000	SAMPLE	03 08012015		195.12	
XXX-XX-XXXX	00000000	SAMPLE	04 12192016		195.12	
XXX-XX-XXXX	00000000	SAMPLE	01 10012013	02	595.05	1,070.74
XXX-XX-XXXX	00000000	SAMPLE	02 10012013		475.69	

9000001288 196/2

Payment remittance – page 3

Important information to record on the remittance sheet includes:

1. Group number
2. Subgroup number
3. Premium paid
4. Invoice number
5. Total amount due per subgroup
6. Total amount paid
7. Preparer's name and phone number



Pg 4 of 4

01/01/2019

****In order to have your payment properly allocated, please fill in the payment amount for each subgroup in the Premium Paid column below. If you are paying for multiple subgroups, please make sure the total premium paid equals the total amount of your check***

INV # Payment Remittance

Group Number: 55555 Date: 12/12/2018

Group Name: XXXX XXXXX XXXXXXX (HDHP/FAM) Billing Period: 01/01/2019 - 01/31/2019

Total Payment Amount: _____ Check #: _____

Group #	Sub #	Premium Paid	Invoice Number	Total Due Per SubGroup
55555	00		201812-50000	$9,518.83

TOTAL: _____ TOTAL DUE FOR ALL SUBGROUPS: $9,518.83

PREPARED BY: _____ Phone #: _____

COMMENTS: _____

9000001290 196/4

Payment remittance

This is the last page of your billing invoice. This will serve as your payment remittance and fund allocation sheet for all premium payments.

To ensure that all payments are properly allocated to the appropriate subgroup, please ensure that the subgroup number and payment amount are written out in their entirety on the payment remittance sheet.

PAYMENT OPTIONS

We offer a variety of payment options to fit your business needs, including check/money order, wire transfer, automated clearing house (ACH), or automated payments via Online Bill Pay.

Check or money order

If you choose to pay via check or money order, please send your payment to the following address and include the payment remittance that was enclosed in your invoice. This information is needed to ensure that your payment is posted properly. Send your payment to:

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

Wire transfer or automated clearing house (ACH)

Bill payment using wire transfer or ACH has become widespread and offers benefits for both the sender and receiver of the funds. Your financial institution can help you decide whether one of these would be a good choice for your company. To initiate a wire transfer or ACH payment, you will need the following information:

Your information

- Group name
- Kaiser Permanente group and subgroup numbers
- Address

Recipient information

- Kaiser Permanente Employer Services
- Address: 2101 E. Jefferson St.
  Rockville, MD 20852

Transfer information

- Payment amount

Receiving financial institution information

This information can be provided to you when you contact Employer Broker Services.

Online Bill Pay

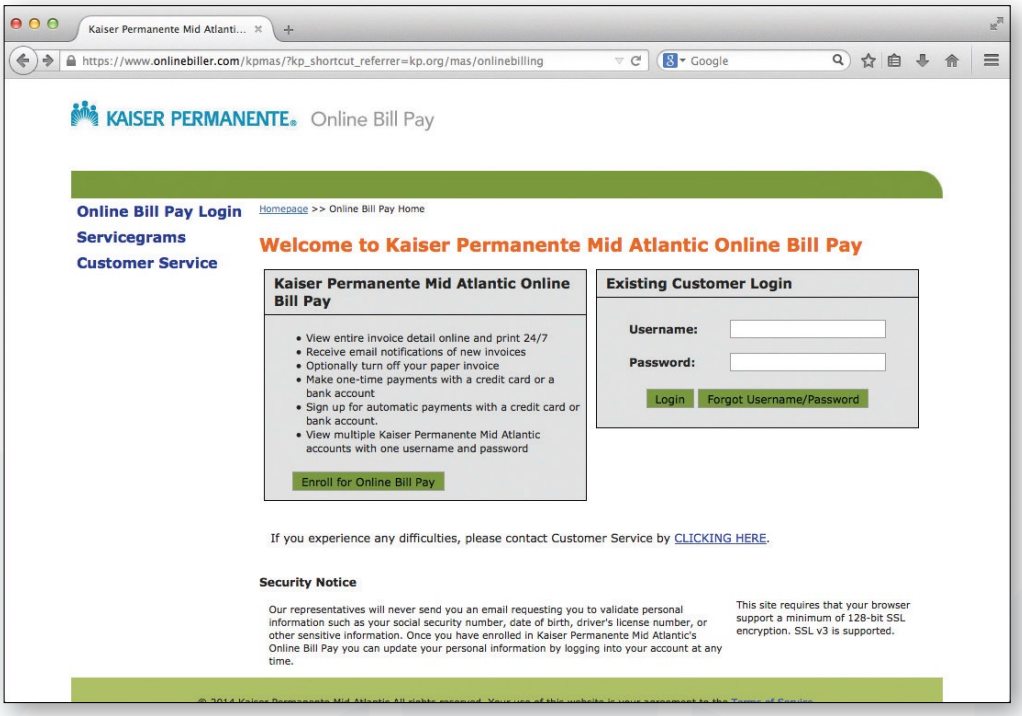
For further ease and convenience in managing your group's health care plan, sign up for Online Bill Pay with Kaiser Permanente today. Once you register for an account, you can:

1. View and pay your entire invoice
2. Receive email notifications for new invoices
3. Eliminate paper invoices
4. Make automatic payments with a bank account
5. View multiple Kaiser Permanente accounts with one username and password
6. Ensure correct payment allocations if you have multiple subgroups

Note: If you have multiple subgroups, please make sure you are registered for each to access all your invoices.

Signing up is easy. Just have your last invoice handy, then visit **kp.org/mas/onlinebilling** and follow these steps:

1. Click the **Enroll for Online Bill Pay** button.



2. Click **Not on a Family Plan.**
   a. For commercial customers, click the **CLICK HERE** link.
3. Find your group number and subgroup numbers on the last invoice(s) you received.
4. Enter the requested information, review the Terms of Service, and click **I AGREE**.
5. Enter your email address.
6. Choose a username and password, then wait for a verification email to be sent to your email account.
7. When you receive the verification email, click on the activation link.
8. Log in to complete registration and begin using Online Bill Pay.

If you have any questions about Online Bill Pay, please contact Employer Broker Services.

GROUP TERMINATION

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

Please note: Discontinuation of premium payments is **not** considered notification of termination of a group policy. Groups will be responsible for all premium payments through the end of the contract period.

Termination by Kaiser Permanente

Kaiser Permanente may terminate a group for any of the following reasons:

1. Fraud or intentionally furnishing incorrect or incomplete information
2. Violation of contribution or participation requirements
3. No eligible person lives, resides, or works in the service area (does not apply to DC SHOP)
4. Non-payment of premium
5. Non-acceptance of amendments

Premium grace period

Except for the binder payment for your group's policy, a 31-day grace period applies to all payments. If payment is not made during the grace period, Kaiser Permanente may terminate your group coverage.

Groups that are terminated for non-payment must pay **all** premiums owed within 30 days before the contract will be considered for reinstatement.

Groups that are terminated for nonpayment twice within a 12-month period will not be eligible for reinstatement. You must reapply for coverage.

If an employee loses coverage

When an employee or dependent loses coverage, there are two options available to continue uninterrupted health plan coverage.

1. Continuation of group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA); for groups with 20 or more employees.
2. Continuation of coverage under District of Columbia, Maryland, or Virginia law when COBRA is not applicable.

Employees who lose group coverage may be eligible for one of our individual and family plans (Kaiser Permanente Individual and Family plans). Kaiser Permanente will send terminated individuals and families a letter notifying them of the group's termination. Notification is sent to the subscriber's address. Terminated employees can visit **kp.org** to view available individual Kaiser Permanente health plans.

More detailed information regarding continuation of coverage can be found on page 27 of this handbook.

COBRA

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

To determine if your employee(s) are eligible for COBRA benefits, the list of qualifying events can be found here: www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html.

Administering COBRA

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

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

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

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

It is the group's responsibility to notify Kaiser Permanente if a canceled member is reinstated under COBRA. Clearly indicate on the Enrollment/Change form that the person is now a COBRA member, as well as the date of his or her reinstatement. Also add the person's name to the monthly statement.

Continuation of coverage

Continuation of coverage was enacted to fill the gap left by federal COBRA continuation of coverage. It applies to all employer groups, including those with fewer than 20 employees.

District of Columbia

D.C. Code § 32-732 provides for **3 months** of continuation of coverage, except in the case of terminations for gross misconduct. The employer is required to provide notice to the employee within 15 days after the date that coverage would otherwise terminate. The employee is responsible for electing coverage and paying the premium within 45 days after the date that coverage would otherwise terminate.

Maryland

Md. Code, Ins. Art. § 15-409 provides for **18 months** of continuation coverage, except in the case of terminations for cause. The employer is required to provide an election form within 14 days of request by an employee. The employee is responsible for electing coverage and paying the premium within 45 days after the date that coverage would otherwise terminate.

Virginia

Va. Code § 38.2-3541 provides for **12 months** of continuation coverage, except in the case of terminations for cause. The employer is required to provide an election form within 14 days after the date that coverage would otherwise terminate. The employee is responsible for electing coverage and paying the premium within 31 days of receiving the notice, but in no event beyond the 60-day period following the date that coverage would otherwise terminate.

OBRA

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

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

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

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

Note: After starting COBRA, members with COBRA coverage have 30 days to remit payment for their premiums.

Form 1095-B, Health Coverage Statement

As part of the Affordable Care Act, Kaiser Permanente is required to send Form 1095-B to subscribers.

5500/Schedule A

Kaiser Permanente will supply Employee Retirement Income Security Act (ERISA) groups with the information necessary to complete the Federal Form 5500 for tax purposes.

The Form 5500-related information will be mailed to the group within 120 days after the end of the group's contract year.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St., Rockville, MD 20852 2019ML0364 MAS 4/15/19-3/31/20