Administrative Handbook for Mid-to-Large Accounts

a guide to managing your account

KAISER PERMANENTE®

CONTENTS

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SECTION 1—Introduction

Welcome to the *Administrative Handbook for Mid-to-Large Accounts.* This handbook is your guide to administering Kaiser Permanente health benefits. Providing you with excellent customer service is always our priority. Think of this handbook as your "go-to guide."

In this handbook, you'll find important contact information, step-by-step reporting instructions, billing and enrollment information, a Q&A section, California service areas, sample statements and forms, and a glossary of useful terms. You'll also find procedures for enrolling members in Medicare, COBRA, and Cal-COBRA.

The handbook has nine main sections:

- **Section 1. Introduction—Welcome to the *Administrative Handbook***
- **Section 2. Accounting Procedures**
- **Section 3. Medicare Overview**
- **Section 4. COBRA and Cal-COBRA Procedures**
- **Section 5. HMO and Deductible HMO (DHMO) Plans**
- **Section 6. Preferred Provider Organization (PPO) Plans, Point-of-Service (POS) Plan, and Out-of-Area Indemnity Plan Accounts**
- **Section 7. Questions and Answers**
- **Section 8. Sample Statements and Forms**
- **Section 9. Glossary**

If you can't find the information you need in this handbook, contact your account manager or the California Service Center (CSC).

Note: The information in this publication was accurate at the time of production. However, from time to time, new details become available after our release date. For the most current news, check with your sales executive or account manager.

INTRODUCTION

Regular reporting of your Kaiser Permanente membership helps to ensure that your employees and their dependents are properly enrolled, that their coverage remains prepaid, and that newly enrolled employees and dependents receive their Kaiser Permanente identification cards.

This section will assist you with the following accounting procedures:

- Membership reporting
- Payment remittance
- Account reconciliation
- Discrepancy resolution

The Kaiser Permanente California Service Center (CSC) manages the administration of customer accounts. The CSC provides contract administration and membership accounting services for all accounts. The CSC enrolls new employers and maintains their membership. In order for the CSC to keep accurate records of your membership, you must submit an enrollment/change form whenever there is a membership transaction (e.g., enrollment, family change, termination) on your account.

The CSC also calculates, bills, and allocates your monthly payments. Since all health care plans are prepaid, you will receive a billing statement for the upcoming coverage period that lists all members and the total amount due. You must make the full payment by the due date to prevent delinquency actions.

The following pages summarize important monthly membership and payment processes, provide the policies and procedures required to maintain a current and active account, and describe the various sections of your monthly bill and payment coupon.

MEMBERSHIP REPORTING AND GUIDELINES

Processing your requests

All membership transaction requests (e.g., enrollments, family change, termination) for new and existing members must be submitted on an enrollment/change form via the Internet on our online Customer Account Services Web site, **kp.org/accountservicestour**, or by an electronic media file. Membership changes cannot be accepted over the telephone.

Open enrollment

Enrollment/change information must be completed and signed by your employee at the time of the open enrollment period set forth in your contract. Delaying this process may cause members to be rejected for coverage. Eligible employees and their eligible dependents who don't enroll when they are initially eligible are subject to the exceptions listed in the *Schedule of Coverage* and *Certificate of Insurance* and may only enroll during their next open enrollment period or qualifying event.

Qualifying events

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

- Increase in an employee's hours so that he or she meets your requirement for medical plan eligibility
- When an employee covered under a different plan moves out of that plan's service area
- When a dependent loses coverage elsewhere
- Marriage
- Addition of a domestic partner
- Divorce or termination of a domestic partner
- Birth
- Adoption of a child
- Death of a spouse, domestic partner, or dependent
- A significant change in the health coverage of the employee, spouse, or domestic partner because of a change in the spouse's or domestic partner's employment
- Court order
- When an employee moves from a job category in which Kaiser Permanente Insurance Company (KPIC) is not offered into a job category in which KPIC is offered
- When an employee who previously lived outside the Kaiser Permanente service area subsequently moves into our service area (This applies to POS members only)

REMINDER

When qualifying events occur, the enrollee doesn't need to wait for open enrollment to enroll.

Medical record numbers (MRNs)

Whenever possible, medical record numbers (MRNs) should be included on all documents and correspondence sent to Kaiser Permanente.

Duplicate MRNs

MRNs are unique and individuals must keep their same number whenever they enroll in a Kaiser Permanente or KPIC product. Multiple MRNs may lead to duplicate or incomplete clinical records and may result in delays when seeking medical care. It is very important that your employees complete the space indicating whether they have ever been a Kaiser Permanente member in the past and listing any other names under which they may have been enrolled. This allows us to issue the same MRN to the member.

Student and disability certification

Your eligibility and enrollment provisions may provide coverage for student and/or disabled dependents who are older than the "child" age limit. The "child" age limit is specified in your Group Agreement. For children attending an accredited school on a full-time basis, the "student" age limit is determined by the employer.

Student certification

If Kaiser Permanente performs your student certifications, the Student Certification form is used for both new enrollments and dependent additions. Enrollment of overage students is dependent upon our receipt of the completed Student Certification form. These dependents will display as pending under the subscriber's account until the certification is received. In general, students must be enrolled in an accredited school. This form must be completed and returned to the CSC within 30 days or the pending request will be canceled. You may obtain additional forms from your Kaiser Permanente representative.

Please see page 8-12, Section 8, Sample Statements and Forms, for a copy of the Student Certification form.

If you perform your own student certification, you must send the certification document to your employee. After they've filled out the form, they should return it to you for verification. You do not need to send the completed form to the CSC.

Disability certification

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

- Notify the benefits administrator
- Complete and submit a disability certification form to the address indicated on the form
- Contact Kaiser Permanente at **1-800-731-4661** for further assistance

If you perform your own disability certification, report the overage dependent to Kaiser Permanente as a disabled dependent using the existing enrollment procedures set forth in your Group Agreement. If Kaiser Permanente currently performs the disability certification process, and you wish to assume this responsibility, please contact your account management team for more information.

Live/work provision

Kaiser Permanente allows individuals who live or work in our service area to enroll in Kaiser Permanente. The live/work provision applies to all non-Medicare subscribers, including COBRA subscribers. Live/work doesn't apply to Kaiser Permanente Senior Advantage or Medicare Cost plans. The customer/employer determines whether to offer the live/work provision. When you send us an enrollment/change form for someone outside our service area, we'll enroll the individual. We'll assume that you have verified eligibility, ensuring that the person lives or works inside our service area in accordance with your Group Agreement.

REMINDER

Members who live outside our service area must receive covered services from Plan providers inside the service area, except as otherwise described in the *Evidence of Coverage*. Also, in accordance with the *Evidence of Coverage*, we can't enroll persons who live in a Kaiser Permanente region outside California.

REMINDER

Members with an active status are also entitled to receive a HIPAA Certificate of Creditable Coverage within a reasonable time following their submission of a written request to Health Plan.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Certificates of Creditable Coverage be issued to terminated members of Kaiser Permanente. The certificates document health care coverage during Kaiser Permanente membership and are the primary means that individuals use to prove prior creditable coverage when seeking new group coverage or coverage in the individual market.

Employee notification

Certificates are issued the first week of each month regarding employees who were terminated in the previous month. Certificates are mailed to the member's home address.

Certificate administration

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

Enrollment/Change Form

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

- Enrollments will not be processed until a completed enrollment/change form is received. Review all enrollment forms for completeness and accuracy before submission to help ensure that all enrollment requests are processed.
- All requests for enrollment must be dated and signed by the subscriber.
- Completed forms should be mailed or faxed to the CSC at the appropriate address or fax number found on page 5-2, Section 5 of this handbook.
- If forms are faxed, it's not necessary to mail the original request.

Completing the enrollment/change form

Forms submitted without complete information or your employee's signature may delay enrollment. Refer to the back of the forms for detailed instructions.

Mandatory fields

The items listed below show the sections on the enrollment/change form that must be completed in order for your membership requests to be processed:

Subscribers

- Last and first names
- Address
- Date of birth
- Gender
- Customer ID
- Enrollment unit
- Signature date
- Event date
- Enrollment reason
- Social Security number

Dependents

- Last and first names
- Address
- Date of birth
- Gender
- Customer ID
- Enrollment unit
- Signature date
- Event date
- Dependent role
- Social Security number

Note: Make sure the customer/purchaser number and date of qualifying event are completed. Please ensure that your employees understand and complete all fields on the form and make sure that you have completed the "To be completed by employer" section. Have your employees return their completed enrollment forms to the appropriate department or individual in your organization for submission to the CSC. All enrollment/change forms must be submitted by you, the employer. Forms submitted directly to Kaiser Permanente by members may be rejected.

Avoiding delays

To prevent delays in processing, completed enrollment/change forms should be submitted to the CSC throughout the month—as you receive them from your employees. The most common reasons for delays in processing enrollments are:

- Missing or inaccurate customer/purchaser numbers, enrollment/billing unit numbers, and/or medical record numbers
- Missing or incomplete birth dates for subscribers and/or dependents
- Missing or incomplete Social Security numbers for subscribers and/or dependents
- Missing or incomplete addresses
- Missing signature of the subscriber
- Missing date of hire or qualifying event
- For new hires, the date of hire not meeting the eligibility rules set by the employer
- Receiving multiple copies of the same request

Member enrollments

When the CSC processes enrollments, the information on the form is compared to the eligibility provisions in your contract. Eligible employees who wish to enroll must complete the enrollment/change form. This form provides us with the information we need to enroll your employees (subscribers) and their eligible family members (dependents). Enrollment/change forms should be signed and submitted within 30 days of the qualifying event.

Your employees must retain the bottom copy of this form for identification until they receive their permanent ID card. Please provide your employees with your customer/purchaser number and their effective date of coverage.

Family account changes

An enrollment/change form must be completed by your employee whenever a dependent is added or deleted. The form must also be completed to report other family changes, such as a new address or name change.

Dependent enrollments

All requests for enrollment of dependents must include the family relationship of the dependent to the subscriber. Verify that the information (e.g., Social Security number and date of birth) is complete for each dependent being enrolled.

Dependent additions

When adding a dependent during any time other than open enrollment, the reason and event date (e.g., marriage date or adoption date) must be included on the enrollment/change form. The CSC will then determine whether the exception meets the eligibility requirements set forth in your contract. Enrollment/change forms for adding dependents must be signed by the subscriber and submitted to the CSC within 30 days of the qualifying event.

Terminations and transfers

The employer must notify Kaiser Permanente of member (i.e., subscriber and/or dependent) terminations and transfers within the standard retroactivity policy.

Terminations

Report employee terminations by filling out a Kaiser Permanente Subscriber Termination and Transfer Form. *Please see page 8-13, Section 8, Sample Statements and Forms, for a copy of this form.*

The employee name, MRN, and employment termination date are required to remove the employee from your monthly bill. The CSC will then terminate the employee/dependent determined by the eligibility end date set forth in your contract.

Subscriber terminations

When a subscriber is terminated, the entire family account is terminated.

- Complete the termination form and submit it to the CSC.
- The minimum fields required to report an employee termination are employee name, MRN, and termination date.

Dependent deletions

The enrollment/change form must be completed and signed by your employee when dependents are deleted from his or her account. The CSC will terminate the dependent's membership based on the eligibility rules for terminations set forth in your contract.

An enrollment/change form can be submitted by the employer to delete an overage dependent. However, our accounting system will automatically terminate the dependent's membership based on the eligibility provision of your contract.

REMINDER

A dependent who is already enrolled, is not a student or a disabled dependent, and reaches the maximum age for unmarried dependents (per your eligibility provisions) must be deleted from the employee's account.

Transfers

Member transfers may be made during open enrollment or during qualifying events. All member transfers must be reported by filling out a new enrollment/change form representing the enrollment to the new billing unit. Be sure to indicate the member's new billing unit number. Membership and dues must be current before transferring from one billing unit to another and vice versa; otherwise, the standard retroactivity policy will apply.

Online account administration—Customer Account Services (CAS)

Our online account services will enable you to:

- Access your health plan account quickly without making a phone call.
- Keep your bills as current as possible by allowing you to enter enrollments and terminations at any time.
- Have more control by maintaining your membership information directly on our systems.
- Pay your bill quickly and easily online with a one-time payment or monthly debits.
- Work according to your schedule, without being limited to Kaiser Permanente service hours.
- Sort and download customer information for specific enrollee types, such as COBRA.

If you haven't signed up for our online account service and would like to enjoy these benefits, please call **1-800-893-2971,** Monday through Friday, 8 a.m. to 5 p.m., or visit us at **employers.kp.org**.

At the site, you can download a registration form and then you can fax it to the location indicated on the form. You'll receive a user ID and password seven days after we receive your registration. Once registered, you'll be able to view your bill, and you'll find step-by-step instructions for using the online account services.

Electronic media file

If you report to Kaiser Permanente via an electronic media file, please send all membership transactions by electronic media file. Subscriber acceptance of the binding arbitration by paper, voice, or electronic processes is required for enrollments reported to Kaiser Permanente by electronic media file.

Inclusion of arbitration text for enrollment forms and voice and electronic enrollment processes

Kaiser Permanente is committed to using binding arbitration as the forum for resolving disputes and has used arbitration to resolve disputes with its members for over 25 years. We believe that arbitration is preferable to court because arbitration can result in less expensive, more efficient resolution of disputes, with greater protection of private patient information. We appreciate the opportunity to partner with customers and their consultants to develop enrollment forms and processes that meet everyone's needs and requirements.

This section is an information guide for customers who use a "universal" enrollment or change form, telephonic Interactive Voice Response (IVR) enrollment process, or electronic (Group Intranet) enrollment process for new and renewing enrollments (rather than the California Region Group enrollment/change form).

Giving notice about binding arbitration

Kaiser Foundation Health Plan, Inc., uses binding arbitration for member disputes. In compliance with California Health and Safety Code Section 1363.1, Health Plan–produced enrollment forms contain mandated binding arbitration notification text in prominent type just above the signature line. Health Plan requires all customers who prefer to use an approved "universal" enrollment form of their own design, or a "universal" enrollment form developed by a consultant or third-party administrator, to also include the appropriate arbitration notification text and the appropriate placement of that text.

Notice for customer-produced enrollment or change forms:

- Health Plan's binding arbitration notification text must appear as a standalone paragraph, just above the signature line, in boldface type for prominence.
- The underlined heading must be included so the enrollee knows that this text is Health Plan–specific.
- The font size of this paragraph must be consistent with the font used throughout the enrollment form and, ideally, must be at least 10 points.

- Customer-produced enrollment forms must be submitted to the customer's account manager or CSC Account Administration Representative (AAR), who will facilitate Health Plan's review and approval process.
- "Universal" enrollment forms must be approved for content and format by both Health Plan Regulatory Services and the CSC prior to use.

Notice for telephonic Interactive Voice Response (IVR) enrollment process

- Health Plan's binding arbitration notification text must be included in the Group's IVR voice script.
- A copy of the Group's voice script must be submitted to the account manager, who will facilitate Health Plan's review and approval process.
- The voice script must be Health Plan–approved prior to use.
- When the employee selects Kaiser Permanente, he or she must hear a recitation of this paragraph. The employee must then press the appropriate telephone key to indicate acceptance or agreement, and the enrollment process will continue. If the employee doesn't accept or agree, the employee must press another key to return to the previous menu to select another offered health care product.

Notice for electronic (Group Intranet) enrollment process

- Health Plan's binding arbitration notification text must appear onscreen when the employee selects Health Plan coverage.
- The employee must click on the appropriate button to agree or accept; then the enrollment process will continue. If the employee doesn't accept or agree, the employee must press another button to return to the previous menu to select another offered health care product.
- A copy of the enrollment screen with the arbitration notification text must be submitted to the customer's account manager, who will facilitate Health Plan's review and approval process.
- The customer's electronic enrollment process will be activated when approved by Health Plan.

PAYMENT REMITTANCE AND REPORTING RULES

As the employer, you are responsible for the reconciliation of your account. Complying with the following information will expedite the time it takes you to review and reconcile your account information each month. Your contract requires you to provide membership information regularly and to prepay the monthly coverage dues for your enrolled members no later than the first day of coverage. Employers who fail to make their payment prior to the beginning of the coverage period risk delinquency actions and may be subject to a late payment charge.

The monthly bill you receive is prospective (i.e., you receive a bill for the upcoming coverage period approximately one month before the coverage period begins). Membership transactions processed after the billing cutoff will appear on your next bill.

Customer/purchaser number and enrollment/billing unit number

You must include your customer/purchaser and enrollment/billing unit numbers on all documents and payments you submit. This is particularly important if you have multiple contracts or billing units. These numbers on the appropriate forms allow for timely and accurate processing of your membership requests and payment allocation.

Delinquency

Be sure to remit your payment before your due date. Remember to allow for mailing and processing time. Employers are subject to delinquency actions for unpaid dues. Unresolved delinquencies may result in automatic termination of your account. Discuss any billing cycle, coverage period, or delinquency rule questions with your Kaiser Permanente representative.

Returned checks

Any check that is returned to us from the bank for nonsufficient funds (NSF) will result in a charge to the employer. This charge will be added to the balance of your account.

Retroactivity

Our retroactivity policy for any membership change is the current month plus or minus two months. Kaiser Permanente allows employers to enroll or terminate members within this time frame. To keep retroactive adjustments to a minimum, submit your completed enrollment/change forms as soon as you receive them from your employees and report any employee terminations on the subscriber termination and transfer form.

Remitting your monthly payment

Payments may be remitted for Health Plan coverage dues by check, wire transfer, automated clearing house (ACH) payment, or via our online banking for employers with access to our online account services.

To remit your monthly payment:

PAYING BY CHECK

1. Prepare a check made payable to Kaiser Foundation Health Plan, Inc., for the total amount due.
2. Write the billing/enrollment unit number on your check.
3. Mail your check with the remittance advice (lower portion of the first page of your bill) before the due date using the envelope provided with your billing statement. Remember to allow for mailing and processing time. Refer to pages 5-2 and 5-3, Section 5 of this handbook for mailing information.

HELPFUL HINT

- Retroactive transactions are any membership or contract changes that are processed during the activity period that have an effective date earlier than the current month being billed.
- The employer is responsible for reviewing all retroactive transactions billed.
- Any problems or questions regarding retroactive effective dates need to be directed to the CSC (see page 5-2, Section 5).

REMINDER

Important things to remember when sending your payment:

- Don't staple your check to the remittance advice.
- Don't send correspondence with your check. Send correspondence separately to the membership address on pages 5-2 or 5-3, Section 5.

Paying online through our online account services (CAS) Web site

If you are currently a registered user of our online account services Web site, you have the ability to view and pay your monthly bill online. You need to establish banking information in order to set up online bill pay functionality. There are two ways for you to pay your bill online:

1. Auto debit is a direct debit function. Each month, total amount due on your billing statement will automatically be withdrawn from your account the day before your bill due date.
2. Pay by Internet is a one-time payment. You will be notified via e-mail when your bill is ready to be viewed. You may then log on to the Customer Account Services Web site to make a one-time payment.

If you haven't signed up for our online account services and would like to learn more, call **1-800-893-2971,** Monday through Friday, 8 a.m. to 5 p.m., or visit us at **kp.org/ouremployers** and select the "Take our virtual tour" link.

Paying by automated clearing house (ACH) payment or wire transfer

You may make electronic payments through ACH payments and wire transfers. ACH payments cost less and are processed within one business day; wire transfers settle on the same day.

To set up ACH payments:

Request that your bank schedule ACH payments and give the following information:

ACH payments	For accounts in Northern California	For accounts in Southern California
Beneficiary name	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
Bank name	Bank of America	Bank of America
ABA number	121000358	122000661
Account number	12334-03557	12350-02104

Request that your bank make payments using the Cash Concentration or Disbursement Plus (CCD+) format. In the field for "Payment Detail/ID Name," insert your billing unit number by following this example:

- If your billing unit number is **000001234-0001,** then enter **PID 001234 EU 0001 ABC Company.**

Note: Insert the letters **PID** and include only enough leading zeros to create a six-digit number. Follow this with a space, the letters **EU,** another space, and enough leading zeros to create a four-digit number. Then enter your company name as it appears on your Kaiser Permanente contract.

To set up a wire transfer:

Provide the bank with this information:

Wire transfers	Accounts in Northern California	Accounts in Southern California
Bank name	Bank of America	Bank of America
Bank address	100 West 33rd St. New York, NY 10001	100 West 33rd St. New York, NY 10001
Account name	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
ABA number	0260-0959-3	0260-0959-3
Account number	12334-03557	12350-02104

In the field for "Payment Detail," insert your billing unit number by following this example:

- If your billing unit number is **000001234-0001,** then enter **PID 001234 EU 0001 ABC Company.**

Note: Insert the letters **PID** and include only enough leading zeros to create a six-digit number. Follow this with a space, the letters **EU,** another space, and enough leading zeros to create a four-digit number. Then enter your company name as it appears on your Kaiser Permanente contract.

In the field for "Comments," insert "Kaiser California Health Plan Membership Dues."

For answers to questions about ACH payments or wire transfers, please contact your account manager. For small business, please contact **1-800-731-4661.**

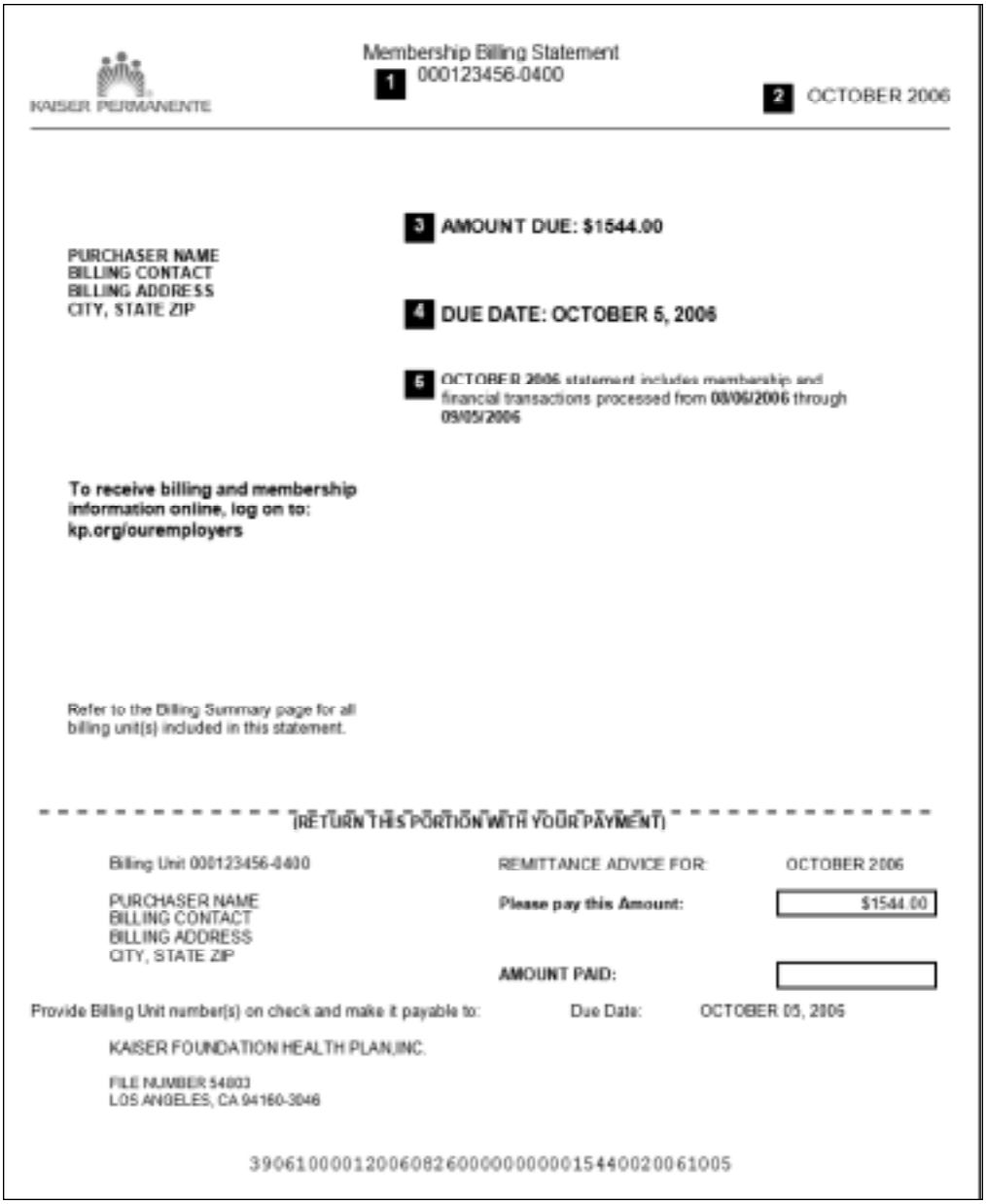
HOW TO READ THE MONTHLY MEMBERSHIP BILLING STATEMENT

Membership billing statement and remittance advice

The monthly membership billing statement includes a remittance advice to submit with payment, as well as a number of sections that provide detailed membership and payment information about your Kaiser Permanente coverage. The membership billing statement displays the coverage month being billed, membership and payment transactions processed for an activity period, and the total amount due.

For easy reference, use the membership and payment addresses located on the first page of the membership billing statement. The bottom portion of the statement page is a remittance advice that is to be returned with your payment. This remittance advice assists us in processing your payment correctly and quickly.

Membership Billing Statement and remittance advice



KAISER PERMANENTE

Membership Billing Statement
1 000123456-0400

2 OCTOBER 2006

3 AMOUNT DUE: $1544.00

PURCHASER NAME
BILLING CONTACT
BILLING ADDRESS
CITY, STATE ZIP

4 DUE DATE: OCTOBER 5, 2006

5 OCTOBER 2006 statement includes membership and financial transactions processed from 08/06/2006 through 09/05/2006

To receive billing and membership information online, log on to:
kp.org/ouremployers

Refer to the Billing Summary page for all billing unit(s) included in this statement.

(RETURN THIS PORTION WITH YOUR PAYMENT)

Billing Unit 000123456-0400

PURCHASER NAME
BILLING CONTACT
BILLING ADDRESS
CITY, STATE ZIP

REMITTANCE ADVICE FOR: OCTOBER 2006

Please pay this Amount: $1544.00

AMOUNT PAID:

Provide Billing Unit number(s) on check and make it payable to:

KAISER FOUNDATION HEALTH PLAN,INC.

FILE NUMBER 54803
LOS ANGELES, CA 94160-3046

Due Date: OCTOBER 05, 2006

3906100001200608260000000000154400200610O5

Field name and description

1 **Primary Billing Unit—**The billing unit of your coverage. This statement reflects transactions for all members covered under this billing unit and secondary (child) billing units.

2 **Coverage Month—**The coverage month for this billing statement.

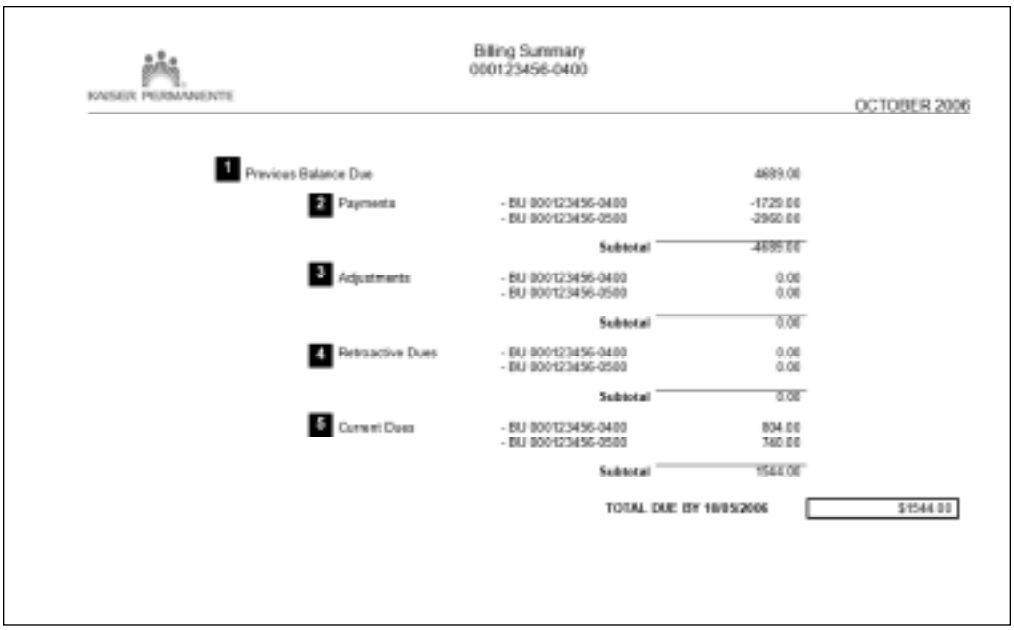
3 **Amount Due—**The total payment due to Kaiser Permanente. This reflects the total amount owed for all open coverage month balances minus all credit balances and unallocated payments for (all) your billing unit(s).

4 **Payment Due Date—**Date by which your payment must be processed. Remember to allow for mailing and processing time.

5 **Activity Period—**Subscriber transactions (membership and billing) processed within this time frame (activity period) will reflect on this bill.

Billing Summary

The Billing Summary section summarizes payment and allocation activities for all billing unit(s).

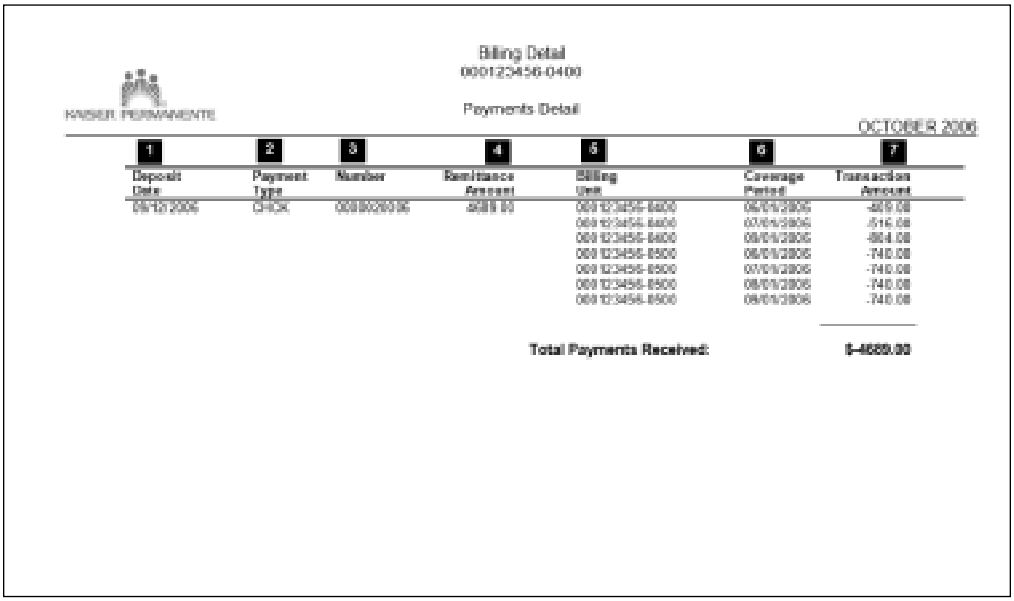


Field name and description

1. **Previous Balance Due—**The total charges from previous month for the entire billing unit family.
2. **Payments—**The amount remitted and allocated for each billing unit(s). For allocation details, see Billing Detail/Payments Detail on page 2-16.
3. **Adjustments—**The charge(s)/credit(s) due for account adjustment transaction(s) for each billing unit(s). For details, see Billing Detail/Adjustments on page 2-17.
4. **Retroactive Dues—**The charge(s)/credit(s) due for retroactive transactions for each billing unit(s). For details, see Billing Detail/Membership Activity Detail on page 2-18.
5. **Current Dues—**The entire amount of current dues for the coverage period for each billing unit(s). For details, see Billing Detail/Current Dues on page 2-21.

Billing Detail/Payments Detail

The Billing Detail/Payments Detail section reflects payments allocated by billing unit and coverage period.

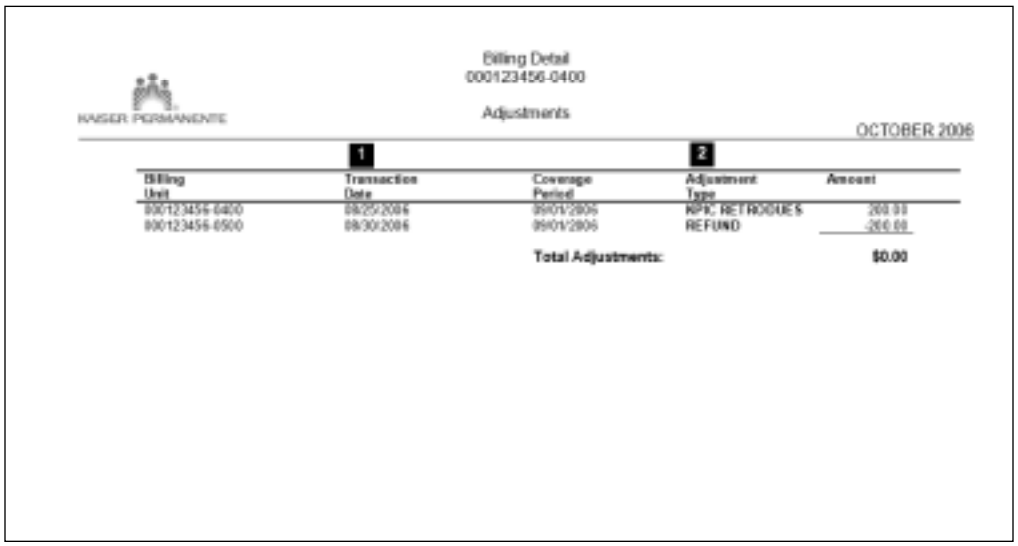


Field name and description

1. **Deposit Date—**The date your payment was processed by our bank.
2. **Payment Type—**The method by which your remittance was sent.
3. **Number—**The check or reference number of your remittance.
4. **Remittance Amount—**The amount of your payment.
5. **Billing Unit—**The billing unit(s) where your payment was applied.
6. **Coverage Period—**The month for which your payment was applied.
7. **Transaction Amount—**The amount that was applied to the corresponding billing unit.

Billing Detail/Adjustments

The Billing Detail/Adjustments section lists the billing unit(s) with adjustments.



Billing Detail
000123456-0400

KAISER PERMANENTE

Adjustments

OCTOBER 2006

Billing Unit	1 Transaction Date	Coverage Period	2 Adjustment Type	Amount
000123456-0400	08/25/2006	09/01/2006	RPC RETRODUES	200.00
000123456-0500	08/30/2006	09/01/2006	REFUND	-200.00
		Total Adjustments:		$0.00

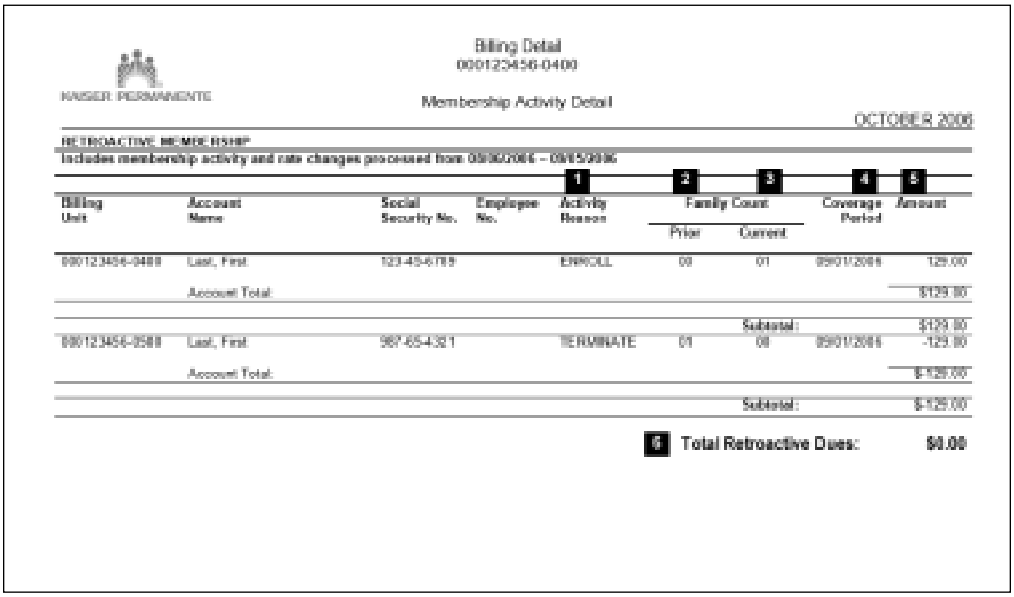
Field name and description

1 **Transaction Date—**The date when the adjustment was processed.

2 **Adjustment Type—**The type of adjustment that resulted from the change of activity or status.

Billing Detail/Membership Activity Detail

The Billing Detail/Membership Activity Detail section lists all transactions processed during the current activity period. These transactions include new enrollments, family account changes, and terminations at the member level. Transactions that can't be processed are listed as rejected. Future enrollments and transactions that require further documentation are listed as pending.


Billing Detail
000123456-0400

KAISER PERMANENTE

Membership Activity Detail

OCTOBER 2006

RETROACTIVE MEMBERSHIP

Includes membership activity and rate changes processed from 09/30/2006 – 09/5/2006

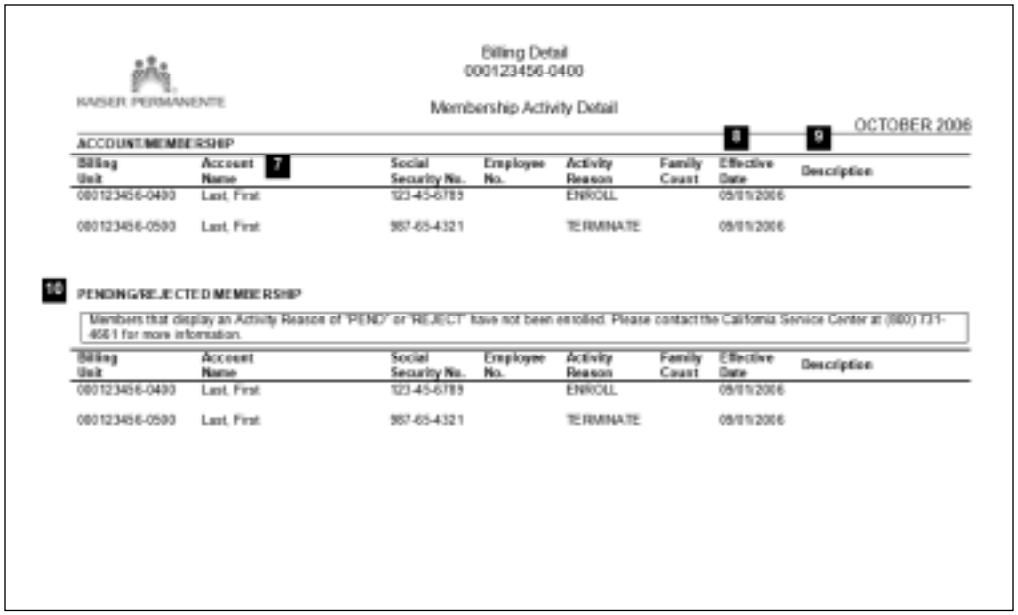
Billing Unit	Account Name	Social Security No.	Employee No.	1 Activity Reason	2 Family Count Prior	3 Family Count Current	4 Coverage Period	5 Amount
000123456-0400	Last, First	123-45-6789		ENROLL	00	01	09/01/2006	129.00
	Account Total:							$129.00
						Subtotal:		$129.00
000123456-0500	Last, First	987-65-4321		TERMINATE	01	00	09/01/2006	-129.00
	Account Total:							$-129.00
						Subtotal:		$-129.00

6 Total Retroactive Dues: $0.00

Field name and description

1. **Activity Reason—**The reason for the retroactive transaction (e.g., enroll, reinstate, terminate).
2. **Prior Family Count—**The number of eligible members in a family prior to the corresponding retroactive transaction being processed.
3. **Current Family Count—**The number of eligible members after the retroactive transaction was processed.
4. **Coverage Period—**The month of coverage for which the retroactive transaction applies.
5. **Amount—**The charge(s)/credit(s) resulting from the retroactive transaction.
6. **Total Retroactive Dues—**The entire amount of retroactive billing for the activity period.

Billing Summary/Membership Activity Detail *(continued)*



Billing Detail
000123456-0400

KAISER PERMANENTE

Membership Activity Detail

OCTOBER 2006

ACCOUNT MEMBERSHIP

Billing Unit	Account Name 7	Social Security No.	Employee No.	Activity Reason	Family Count	Effective Date 8	Description 9
000123456-0400	Last, First	123-45-6789		ENROLL		09/01/2006	
000123456-0500	Last, First	987-65-4321		TERMINATE		09/01/2006	

10 PENDING/REJECTED MEMBERSHIP

Members that display an Activity Reason of 'PEND' or 'REJECT' have not been enrolled. Please contact the California Service Center at (800) 731-4661 for more information.

Billing Unit	Account Name	Social Security No.	Employee No.	Activity Reason	Family Count	Effective Date	Description
000123456-0400	Last, First	123-45-6789		ENROLL		09/01/2006	
000123456-0500	Last, First	987-65-4321		TERMINATE		09/01/2006	

Field name and description

7 **Account Name—**The members who have membership activity changes processed during the activity period.

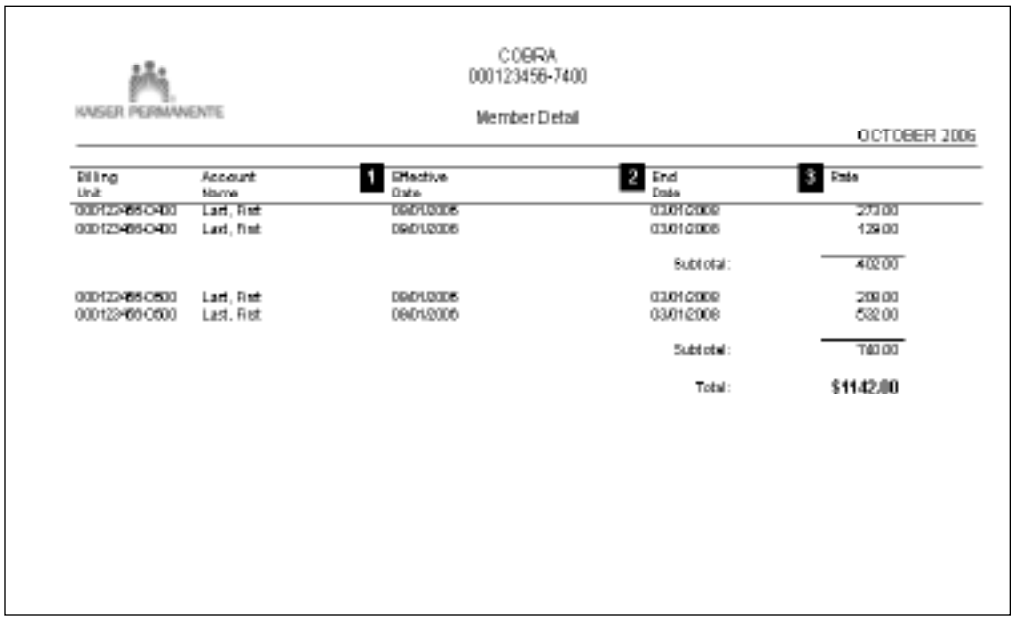
8 **Effective Date—**The date on which the coverage becomes effective.

9 **Description—**The contract option that is affected by the activity.

10 **Pending/Rejected Membership—**The members for whom the activity has not been processed because the transaction either has a future effective date or requires further documentation (i.e., student certification).

COBRA/Member Detail

The COBRA/Member Detail section only applies to employers with COBRA members. This section lists all COBRA accounts on a member level.



COBRA
000123456-7400

KAISER PERMANENTE

Member Detail

OCTOBER 2006

Billing Unit	Account Name	1 Effective Date	2 End Date	3 Rate
000123456C400	Last, First	09/01/2006	03/01/2009	270.00
000123456C400	Last, First	09/01/2006	03/01/2009	129.00
			Subtotal:	402.00
000123456C500	Last, First	09/01/2006	03/01/2009	209.00
000123456C500	Last, First	09/01/2006	03/01/2009	532.00
			Subtotal:	740.00
			Total:	$1142.00

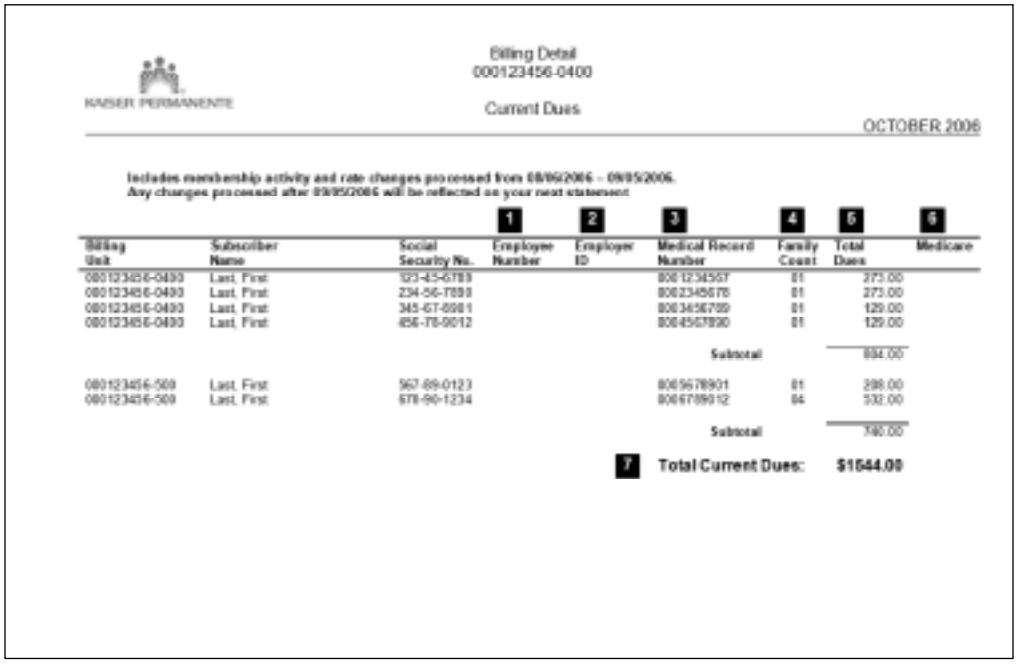
Field name and description

1. **Effective Date—**The start date of COBRA coverage.
2. **End Date—**The end date of COBRA coverage.
3. **Rate—**The amount due for each member.

Billing Detail/Current Dues

The Billing Detail/Current Dues section reports dues by family account (per subscriber). The members shown on the detail are eligible for coverage during the coverage month.

If you have requested a detail at the member level (subscriber and their dependents individually listed), this section is replaced by the Billing Detail/Membership Current Dues section (see below).



Billing Detail
000123456-0400

KAISER PERMANENTE

Current Dues

OCTOBER 2006

Includes membership activity and rate changes processed from 09/09/2006 - 09/05/2006.
Any changes processed after 09/05/2006 will be reflected on your next statement

Billing Unit	Subscriber Name	Social Security No.	1 Employee Number	2 Employer ID	3 Medical Record Number	4 Family Count	5 Total Dues	6 Medicare
000123456-0400	Last, First	123-45-6789			000123456T	01	273.00	
000123456-0400	Last, First	234-56-7890			000234567B	01	273.00	
000123456-0400	Last, First	345-67-8901			000345678D	01	129.00	
000123456-0400	Last, First	456-78-9012			000456789D	01	129.00	
					Subtotal		804.00	
000123456-509	Last, First	567-89-0123			000567890T	01	288.00	
000123456-509	Last, First	678-90-1234			000678901D	04	532.00	
					Subtotal		740.00	

7 Total Current Dues: $1544.00

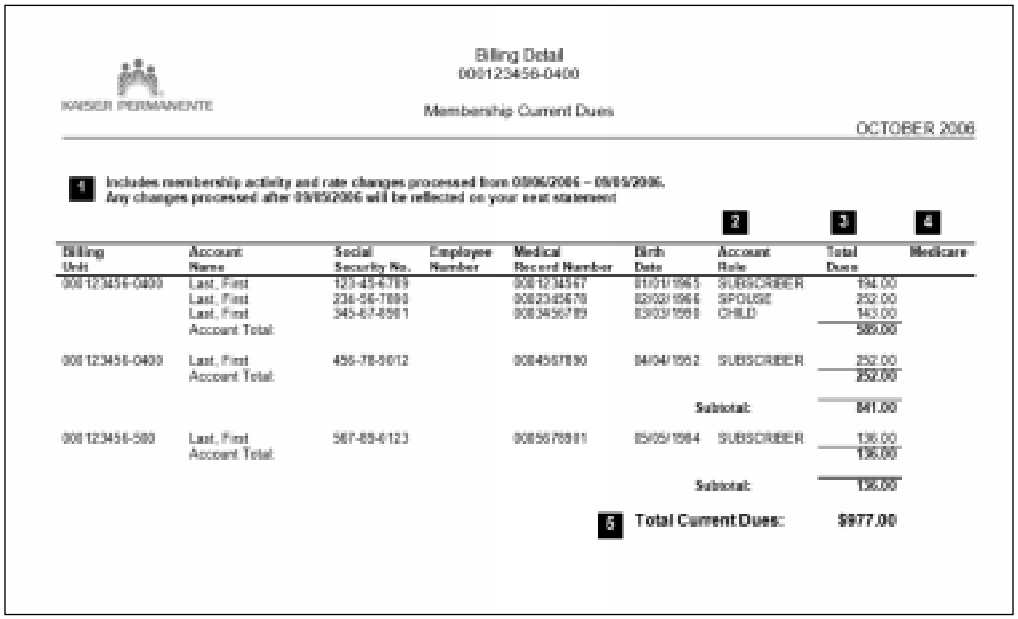
Field name and description

1. **Employee Number—**The number for the member as provided by the customer (blank if none provided).
2. **Employer ID—**The number of the location to which the member is assigned as provided by the customer (blank if not maintained for your billing unit).
3. **Medical Record Number—**The primary identifier assigned to each member by Kaiser Permanente.
4. **Family Count—**The number of eligible members in a family.
5. **Total Dues—**The entire amount billed and due for each subscriber.
6. **Medicare—**The Medicare status for the family account. A "Y" indicates that at least one member in the family has Medicare. An "N" indicates that the subscriber is at least 65 and eligible for Medicare, but has not assigned their Medicare Part B to Kaiser Permanente.
7. **Total Current Dues—**The total amount due for all subscribers for the coverage period.

Billing Detail/Membership Current Dues

The Billing Detail/Membership Current Dues section lists all subscribers and their dependents that are eligible for coverage during the coverage month.

If you have requested a detail at the subscriber level (dues of subscriber and dependents combined), this section is replaced by the Billing Detail/Membership Current Dues section (see below).



Billing Detail
000123456-0400

KAISER PERMANENTE

Membership Current Dues

OCTOBER 2006

1 Includes membership activity and rate changes processed from 09/06/2006 – 09/19/2006. Any changes processed after 09/19/2006 will be reflected on your next statement

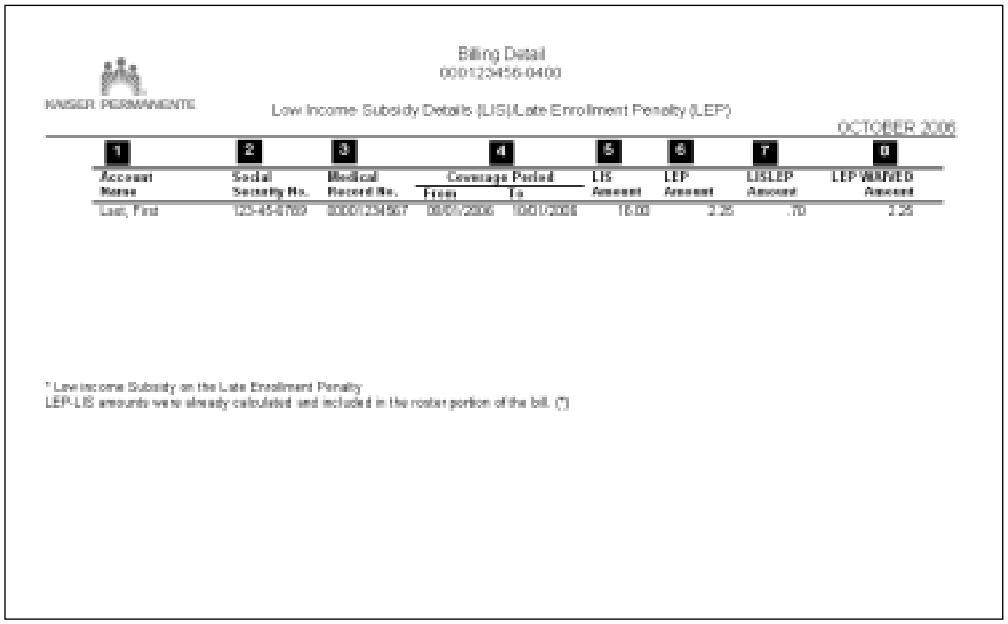
Billing Unit	Account Name	Social Security No.	Employee Number	Medical Record Number	Birth Date	2 Account Role	3 Total Dues	4 Medicare
000123456-0400	Last, First	123-45-6789		000123456	01/01/1965	SUBSCRIBER	184.00	
	Last, First	236-56-7890		000234567	02/03/1966	SPOUSE	252.00	
	Last, First	345-67-8901		000345678	03/03/1998	CHILD	143.00	
	Account Total:						580.00	
000123456-0400	Last, First	456-78-9012		000456789	04/04/1952	SUBSCRIBER	252.00	
	Account Total:						252.00	
						Subtotal:	841.00	
000123456-580	Last, First	567-89-0123		000567891	05/05/1964	SUBSCRIBER	136.00	
	Account Total:						136.00	
						Subtotal:	136.00	
						5 Total Current Dues:	$977.00	

Field name and description

1. **Membership Activity—**Transactions processed within this time frame to reflect on this bill.
2. **Account Role—**The covered member's relationship to the subscriber.
3. **Total Dues—**The entire amount billed and due for each member.
4. **Medicare—**The Medicare status for the member. A "Y" indicates that the member has Medicare. An "N" indicates that the member is at least 65 and eligible for Medicare, but has not assigned their Medicare Part B to Kaiser Permanente.
5. **Total Current Dues—**The amount due for each member for the coverage period.

Low-Income Subsidy Details/Late Enrollment Penalty

The Billing Detail/Low-Income Subsidy Details (LIS)/Late Enrollment Penalty (LEP) section reflects Medicare members' LIS/LEP status and any charges associated with their account.

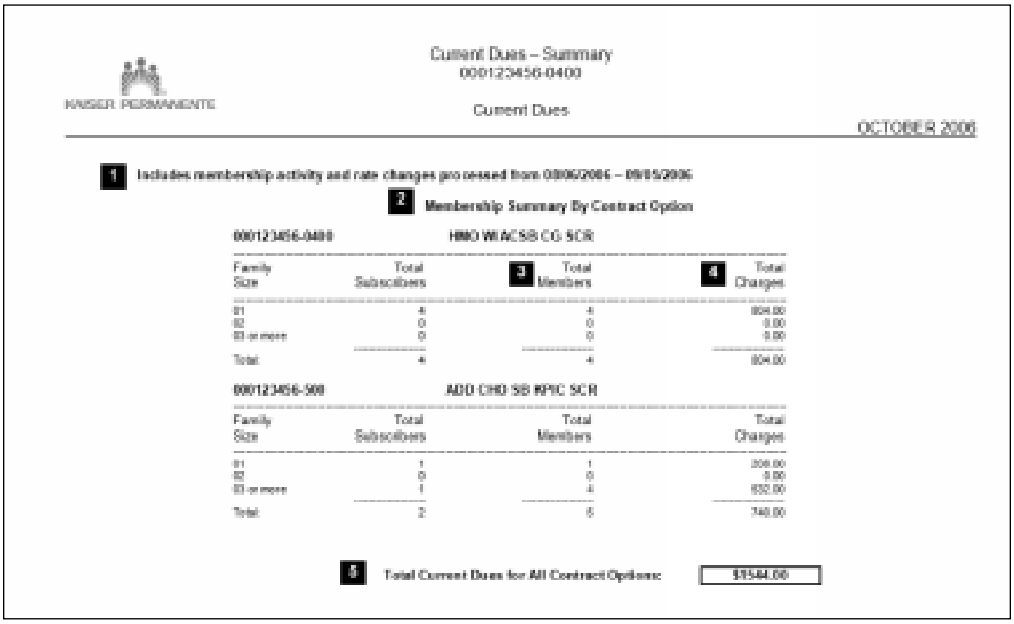


Field name and description

1. **Account Name—**The name of the Medicare member.
2. **Social Security No.—**The Social Security number of the member.
3. **Medical Record No.—**The primary identifier assigned to each member by Kaiser Permanente.
4. **Coverage Period—**The month for which the charges apply.
5. **LIS Amount—**The amount credited from Low Income Subsidies.
6. **LEP Amount—**The amount billed as a Late Enrollment Penalty.
7. **LISLEP Amount—**The amount credited to Late Enrollment Penalties from Low Income Subsidies.
8. **LEP WAIVED Amount—**The amount waived from the Late Enrollment Penalty.

Current Dues—Summary

The Current Dues—Summary section lists the total charges and number of members for each contract option that applies to your group.



Current Dues – Summary
000123456-0400

KAISER PERMANENTE

Current Dues

OCTOBER 2006

1 Includes membership activity and rate changes processed from 08/06/2006 – 09/05/2006

2 Membership Summary By Contract Option

000123456-0400 HMO WI ACSB CG SCR

Family Size	Total Subscribers	3 Total Members	4 Total Charges
01	4	4	804.00
02	0	0	0.00
03 or more	0	0	0.00
Total:	4	4	804.00

000123456-500 ADD CHD SB RPIC SCR

Family Size	Total Subscribers	Total Members	Total Charges
01	1	1	208.00
02	0	0	0.00
03 or more	1	4	532.00
Total:	2	5	740.00

5 Total Current Dues for All Contract Options: $1544.00

Field name and description

1. **Membership Activity—**Transactions processed within this time frame to reflect on this bill.
2. **Contract Option—**The contract options that are available to you and the current dues for each option.
3. **Total Members—**The total number of members for the contract option for the coverage period.
4. **Total Charges—**The total dues for each contract option for the coverage period.
5. **Total Current Dues—**The total dues for all the contract options combined for the coverage period.

Discrepancies from self-reporting customers

When we process your monthly premium report and reconcile your account, we may find you've made overpayments or underpayments that result in discrepancies. We'll send you a Reconciliation Discrepancy Report. The Reconciliation Discrepancy Report also itemizes the net discrepancy amount. Please review the reconciliation, research each discrepancy, and respond to any discrepancies listed with your next premium payment. This report is also available electronically from your CSC AAR.

Please see page 8-7, in Section 8, Sample Statements and Forms, for a copy of the Reconciliation Discrepancy Report.

Reading reconciliation reports

- The Reconciliation Discrepancy Reports are generated after your payment has been processed and the reconciliation has been completed. The reports reflect membership and payment transactions that occurred during the reporting/activity period for the applicable coverage period.
- The reporting/activity period is the time period between dues calculations and/or reconciliations. The coverage period is the time period you are paying for and for which the member/employee is eligible to receive medical care.

Resolving discrepancies

Discrepancies can be resolved by paying the amount due, correcting the membership, correcting the reported discrepancy (for example, by effective/termination date), or submitting the missing documentation.

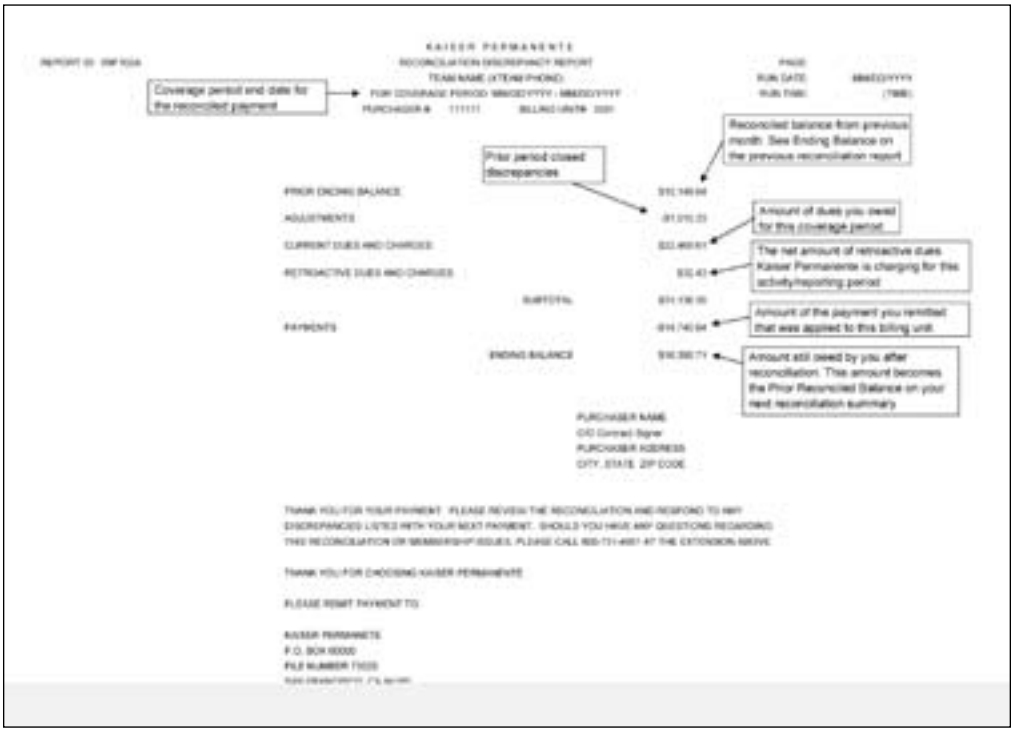
HELPFUL HINT

Being consistent and timely in reporting membership and making premium payments will minimize discrepancies.

Discrepancy report (electronic media and self-reporting customers)

Use this reconciliation summary to verify the allocation of the payment you remitted. It is a financial snapshot of your account after Kaiser Permanente has processed your payment.

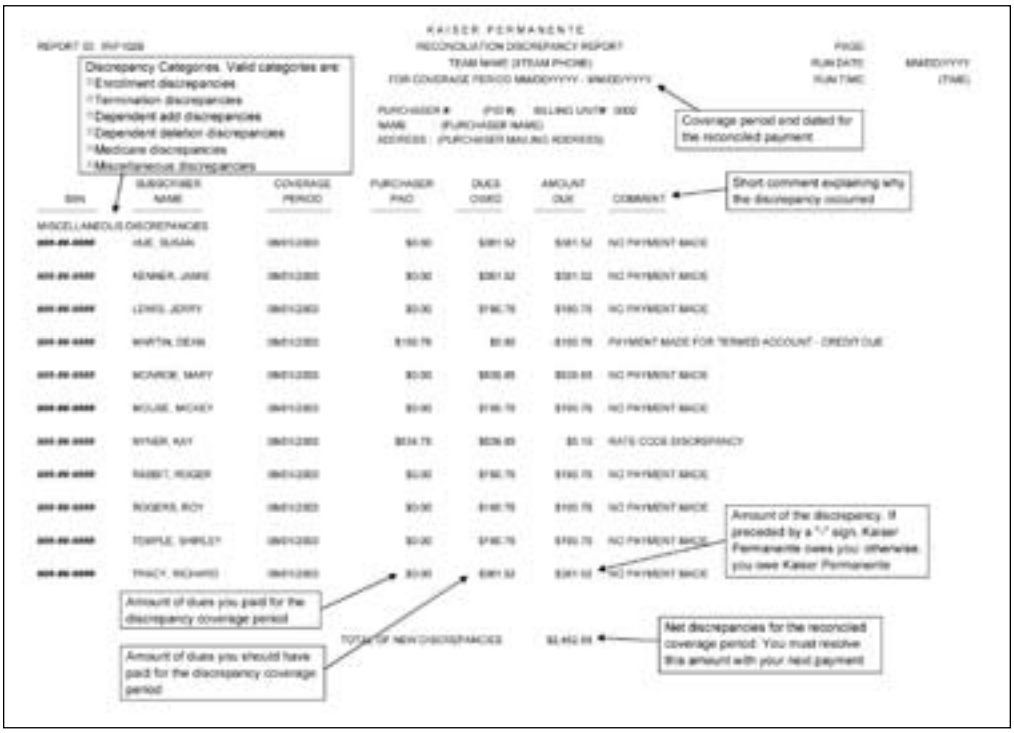
Please see Page 8-7, Section 8, Sample Statements and Forms, for a copy of the Reconciliation Discrepancy Report.



Reconciliation Summary in the Discrepancy Report

The Reconciliation Discrepancy Report lists all new discrepancies for the reconciled coverage period. This report is not cumulative. You must refer to previous report(s) when researching and resolving prior discrepancies.

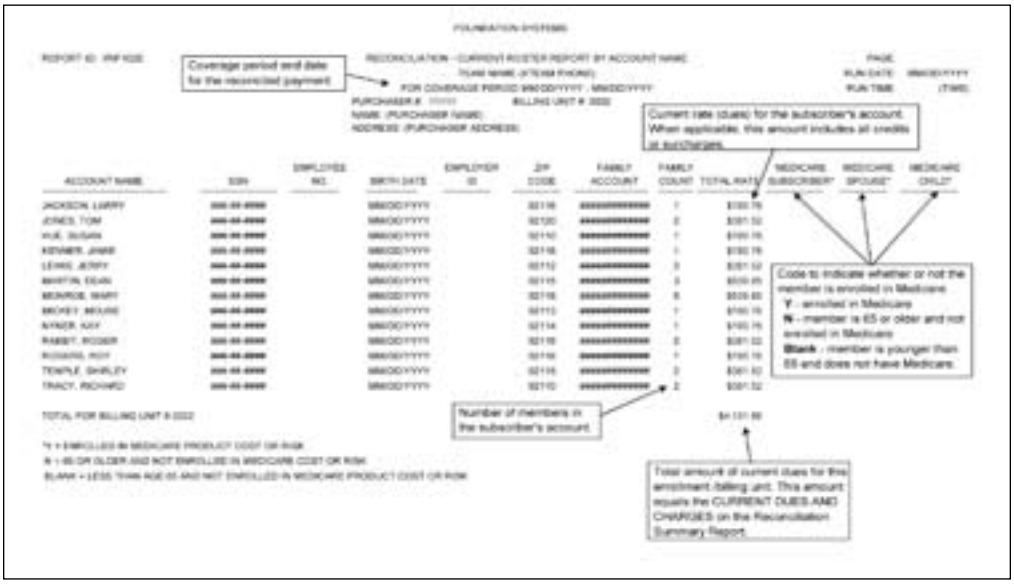
Please see page 8-7, Section 8, Sample Statements and Forms, for a copy of the Reconciliation Summary in the Discrepancy Report.



Reconciliation Current Roster Report by Account Name

The Reconciliation Current Roster Report lists all current subscribers for the enrollment/billing unit reconciled. The report also gives the current rate for each subscriber and indicates whether he or she is enrolled in Medicare. Use this report to verify the subscribers in each of your enrollment/billing units.

Please see page 8-8, Section 8, Sample Statements and Forms, for a copy of the Reconciliation Current Roster Report by Account Name.



Reconciliation Membership Summary by Contract Option

The Reconciliation Membership Summary by Contract Option Report provides you with the total numbers of members enrolled under your group plan by contract option as well as family composition.

Please see page 8-8, Section 8, Sample Statements and Forms, for a copy of the Reconciliation Membership Summary by Contract Option.

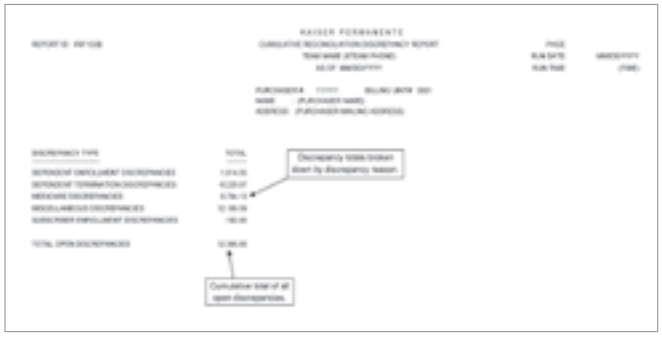
Please see page 8-9, Section 8, Sample Statements and Forms, for a copy of the Reconciliation Discrepancy Report by Contract Option.

Cumulative Reconciliation Discrepancy Report (self-reporting customers)

This report provides you with a page that includes your discrepancy totals, broken down by discrepancy type. This report is also available electronically from your CSC AAR. The main body of the report can also be sorted by discrepancy type.

Cumulative Reconciliation Discrepancy Report—Totals

Please see page 8-9, Section 8, Sample Statements and Forms, for a copy of the Cumulative Reconciliation Discrepancy Report.



Cumulative Reconciliation Discrepancy Report—Subscriber Totals

Please see page 8-10, Section 8, Sample Statements and Forms, for a copy of the Cumulative Reconciliation Discrepancy Report.

Late Payment Charge policy and options

- Kaiser Permanente is a prepaid health plan. Our standard Group Agreement requires customers to pay by the first day of the coverage month. If a customer pays after the first day of the coverage month, the dues may include an additional charge. The purpose of this charge is to compensate Kaiser Permanente for the costs of a late payment and any associated administrative expenses.
- Our Group Agreement states that we may include a charge if payment is received after the first day of the coverage month. For administrative ease, we define "late" for all medium/large employers as occurring when Kaiser Permanente or its assigned financial institution receives payment after the close of business on the 15th day of the coverage month (if the 15th falls on a weekend or federal holiday, then after the first business day following the 15th).
- Eligibility for the Late Payment Charge is assessed annually.
- When the customer has paid 13 or more half-months late in a 12-month period, the customer may qualify for Late Payment Charge.

Late Payment Charge dues rate load: A payment option under the Late Payment Charge

- Late Payment Charge is assessed when the customer has made late payments totaling 13 or more half-months in a 12-month period.
- Late Payment Charge notification letter is sent to the customer, describing the policy and other available alternative payment options.
- The Late Payment Charge is based on an equivalent per dues paying unit (DPU). The DPU rate follows the rate step calculation. A rate expressed as per DPU is a single rate. The per-DPU rate is multiplied by the step ratios to arrive at the rate for family coverage.
- Late Payment Charges will be reassessed and adjusted for any changes in late payment practices each contract year.
- Weighted average (rollup) is the basis for the Late Payment Charge calculation for the number of half-months late for groups with multiple billing or enrollment units. Biweekly will be considered for Late Payment Charge.
- Tenthly employers are not considered late until the first day of the month following the month of coverage. (A "tenthly" employer is one that gets only 10 bills in a year.)
- Once Late Payment Charge has been determined, it is applied to all customer enrollment units, including COBRA accounts.

Advance deposit: A payment option under the Late Payment Charge

- An advance deposit allows the employer's payment to be received by the 15th of the month following the month of coverage.
- An advance deposit and Late Payment Charge may be simultaneously applied.
- Advance deposits may be made in half-month increments for customer accounts paying $300,000/month in dues or more.
- Employers must submit the agreed-upon advance deposit amount with the remittance form 90 days prior to their renewal, or their rate quotes will be revised to include the Late Payment Charge.

Late Payment Charge letter of agreement: Can be used to waive or reduce the Late Payment Charge

- Those customers who evidence a commitment to resuming timely payments may be offered a letter of agreement. In the letter of agreement, the customer commits to correcting its late payment practices and Kaiser Permanente waives or reduces the Late Payment Charge for the upcoming renewal.
- If the customer doesn't act in accordance with the terms of the letter of agreement and improve its payment practices, there may be a double load assessed at renewal time to compensate Kaiser Permanente for the load waived and current payment practice load.

Estimated payment: A payment option under the Late Payment Charge

- Estimated payment is an option to pay an estimated payment equal to 95 percent of the customer's prior monthly dues by the first day of the coverage month.
- The customer must pay the balance of 5 percent, adjusted for membership additions and terminations, by the end of the coverage month.

OVERVIEW

Senior status: A transition in health care

Retirement brings a new dimension to health care. Because most employees turn to their employers for help in this transition, benefits administrators must be prepared to answer questions about Medicare as well as general health care coverage.

To assist you in answering questions about Medicare coverage for Medicare beneficiaries, as well as about general health care coverage, you can now access the Medicare and Kaiser Permanente Senior Advantage handbook online on **kp.org/medicare**.

Outline

- Introduction
- Medicare Overview
- Kaiser Permanente's Medicare Plans
- Eligibility
- Enrollment
- How to Join Senior Advantage
- Involuntary Disenrollment from Senior Advantage
- Reporting
- Roles and Responsibilities
- Policy Decisions the Employer Must Make

Your Health Plan account manager and California Service Center Administrative Account Representatives (CSC AARs) can answer any additional questions you may have on the issues outlined above.

INTRODUCTION

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

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

Under the Employee Retirement Income Security Act (ERISA), the employer's Employee Welfare Benefit Plan has the fiduciary responsibility for all aspects of COBRA administration. The Plan Administrator (as defined by ERISA) is the employer or a third-party administrator appointed by the employer. Kaiser Permanente performs only clerical COBRA functions for employer groups. It has not and does not accept fiduciary responsibility as a COBRA administrator for any employer group. Kaiser Permanente is, however, a Plan Fiduciary (as defined by ERISA solely) for determining the scope and extent of health care coverage for those ERISA Plan beneficiaries enrolled through the group as our members, including those participating through COBRA. If your employees call Kaiser Permanente for federal COBRA enrollment information, they will be told to contact their employer for assistance.

COBRA

Monthly billing of your COBRA members

The billing and collecting of COBRA premiums can be accomplished in two ways:

1. You (or your designee) can bill and collect the premiums for all your COBRA members, in which case, you (or your designee) will pay Kaiser Permanente for all your COBRA members as a group, just as you do for your active employees. For example, you would not send Kaiser Permanente individual payments for each COBRA member. Note: A designee refers to a third-party administrator that you contract with to perform some or all of your group's COBRA administration functions.

2. You can ask Kaiser Permanente to bill each COBRA member and collect his or her premiums.

Kaiser Permanente billed federal COBRA activity report

Kaiser Permanente will mail you this report each month to notify you of the membership status of your federal COBRA members for which Kaiser Permanente does the billing and collecting. This report will be generated monthly on approximately the 19th of each month, and should be received by you approximately 10 days later. The report will provide the COBRA member's name, Social Security number, address, family role, and

start and expected end date for COBRA coverage, so that you can easily see your active COBRA members (for which Kaiser Permanente does the billing and collecting), those who have failed to make timely payments, and those who are being terminated (either for nonpayment or for reaching the maximum period of COBRA coverage). If there is no COBRA activity for a reporting period, you will not receive this report.

How to enroll COBRA members

When an employee or dependent chooses to elect Kaiser Permanente COBRA coverage, he or she must complete a Kaiser Permanente COBRA enrollment form, which must be submitted directly to the group. You will then submit the enrollment form and report any terminations in the way you usually report membership changes. We will not accept any COBRA enrollment forms directly from your employees. Kaiser Permanente will accept enrollment only for the minimum time frames as specified in COBRA. If you have COBRA participants who elect to change their health coverage to Kaiser Permanente at open enrollment, the enrollment form must include their original COBRA start date. 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:

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

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.

Termination of employer contract

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

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 of the original COBRA start date(s) of the participant(s).

CAL-COBRA

The California Continuation Benefits Replacement Act (Cal-COBRA) allows continued access to group health coverage by:

- Former employees and their dependents of employers of 2 to 19 eligible employees (including church groups).
- Enrollees who have exhausted continuation coverage under federal COBRA, if the enrollee is entitled to less than 36 months of federal COBRA.

Cal-COBRA coverage is available for up to 36 months to:

- Subscribers and dependents who have exhausted continuation coverage under federal COBRA if the subscriber and dependents are entitled to less than 36 months of federal COBRA.
- Subscribers and dependents when the subscriber loses employment with the customer through which he or she enrolled for reasons other than gross misconduct.
- Subscribers and dependents when the subscriber's hours are reduced and he or she no longer qualifies for group coverage.
- A dependent who loses group coverage due to divorce or legal separation.
- A dependent who loses group coverage due to death of the subscriber.
- A dependent child who marries or reaches the age limit for group membership or who experiences a change in custody.
- A dependent when a subscriber becomes entitled to Medicare.

Billing and payment

Kaiser Permanente handles billing and collection of payments for Cal-COBRA. Dues are billed by and paid to the Health Plan. Kaiser Permanente bills and collects directly from the subscriber.

Please request an updated report from us whenever you need to know which former employee(s) are enrolled through your Cal-COBRA account.

Employee notification—small-employer customers

Employers with 2 to 19 employees must notify Kaiser Permanente within 31 days of an employee's loss of group health care coverage eligibility. If the loss of eligibility is due to gross misconduct, employers should notify Kaiser Permanente within five business days. Employees terminated for gross misconduct are not eligible for COBRA or Cal-COBRA.

Kaiser Permanente sends a notice of the availability of the Cal-COBRA program to all group members terminating group health care coverage. The notice is included with other options that may be available. If your employees have any questions about Cal-COBRA, have them contact a member service representative at **1-800-464-4000.**

Member notification for those enrolled in federal COBRA

Kaiser Permanente will notify members who have exhausted their COBRA coverage (if they're entitled to fewer than 36 months of federal COBRA) of their opportunity to enroll in Cal-COBRA and extend the term of their continuation coverage to 36 months. The notice is included with other options that may be available. If your employees have any questions about COBRA, have them contact a member service representative at **1-800-464-4000.**

HMO and DHMO—Wide access to Kaiser Permanente's unique integrated health care system.

Your employees will enjoy a full range of health care services, often in one convenient location, saving them time and worry. With everything under one roof, care can be efficiently coordinated among physician, specialist, lab, pharmacy, and other clinical staff for better employee health and productivity. Our HMO plans also offer some of the most reasonable rates in the marketplace. By adding a deductible, you'll find that our traditional HMO becomes an even more cost-effective choice.

HMO COPAYMENT PLANS—Comprehensive benefits with first-dollar coverage; peace of mind from predictable payments.

DEDUCTIBLE HMO PLANS—Wide range of premium levels and cost-sharing options.

KAISER PERMANENTE SENIOR ADVANTAGE—Our Medicare Advantage program for current Health Plan members and for potential members who are entitled to Medicare Part A and enrolled in Medicare Part B, or enrolled in Medicare Part B only.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)—A federally mandated requirement for companies that employ at least 20 workers (both full- and part-time); a safety net for most employees and their covered dependents if they lose group coverage.

IMPORTANT ADDRESSES AND PHONE NUMBERS

CALIFORNIA SERVICE CENTER (CSC)

The CSC is available to answer your questions about:

- Billing
- Eligibility
- Enrollment/change forms
- Monthly payments

Call **1-800-731-4661,** Monday–Friday, 8 a.m.–5 p.m.

Fax enrollment/change forms to:

(858) 614-3344 (Northern California)

(858) 614-3345 (Southern California)

If you fax documents, please don't mail originals.

Membership and Payment Mailing Addresses

Use the following addresses to mail membership documents (enrollments, family account changes, terminations) and payments.

Northern California

Contacts	Mail correspondence (other than payments) to	Mail payments to
Kaiser Permanente Billed and Collected COBRA	Kaiser Permanente California Service Center P.O. Box 23059 San Diego, CA 92193-3059	Kaiser Foundation Health Plan, Inc. P.O. Box 7141 Pasadena, CA 91109-7141
Self-Reporting	Kaiser Permanente California Service Center P.O. Box 23448 San Diego, CA 92193-3448	Kaiser Foundation Health Plan, Inc. P.O. Box 60000 File #73029 San Francisco, CA 94160-3029
Billed	Kaiser Permanente California Service Center P.O. Box 23219 San Diego, CA 92193-3219	Kaiser Foundation Health Plan, Inc. P.O. Box 60000 File #73030 San Francisco, CA 94160-3030

Note: Always verify the payment address on the billing invoice.

IMPORTANT ADDRESSES AND PHONE NUMBERS

Southern California

Contacts	Mail correspondence (other than payments) to	Mail payments to
Kaiser Permanente Billed and Collected COBRA	Kaiser Permanente California Service Center P.O. Box 23127 San Diego, CA 92193-3127	Kaiser Foundation Health Plan, Inc. P.O. Box 7141 Pasadena, CA 91109-7141
Self-Reporting	Kaiser Permanente California Service Center P.O. Box 23758 San Diego, CA 92193-3758	Kaiser Foundation Health Plan, Inc. Worldway Postal Center P.O. Box 80204 Los Angeles, CA 90080-0204
Billed	Kaiser Permanente California Service Center P.O. Box 23250 San Diego, CA 92193-3250	Kaiser Foundation Health Plan, Inc. File 5915 Los Angeles, CA 90074-5915

AUTOMATED CLEARING HOUSE (ACH) INFORMATION

Request that your bank schedule ACH payments and give the following information:

ACH payments	Accounts in Northern California	Accounts in Southern California
Beneficiary name	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
Bank name	Bank of America	Bank of America
ABA number	121000358	122000661
Account number	12334-03557	12350-02104

- Request that your bank make payments using the Cash Concentration or Disbursement Plus (CCD+) format.
- In the field for **"Payment Detail/ID Name,"** insert your billing unit number by following this example:
  - If your billing unit number is **000001234-0001,** then enter **PID 001234 EU 0001 ABC Company.**
  - Insert the letters **PID** and include only enough leading zeros to create a six-digit number. Follow this with a space, the letters **EU,** another space, and enough leading zeros to create a four-digit number.
  - Then enter your company name as it appears on your Kaiser Permanente contract.

IMPORTANT ADDRESSES AND PHONE NUMBERS

WIRE TRANSFERS

Provide the bank with this information:

Wire transfers	Accounts in Northern California	Accounts in Southern California
Bank name	Bank of America	Bank of America
Bank address	100 West 33rd St. New York, NY 10001	100 West 33rd St. New York, NY 10001
Account name	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.
ABA number	0260-0959-3	0260-0959-3
Account number	12334-03557	12350-02104

How to fill in the Payment Detail field:

- In the field for **"Payment Detail,"** insert your billing unit number by following this example: If your billing unit number is **000001234-0001,** then enter **PID 001234 EU 0001 ABC Company.**
- Insert the letters **PID** and include only enough leading zeros to create a six-digit number. Follow this with a space, the letters **EU,** another space, and enough leading zeros to create a four-digit number.
- Then enter your company name as it appears on your Kaiser Permanente contract.

Client Services Unit (CSU)—previously known as the Purchaser Services Unit (PSU)

When you need answers, the first call you make should be the only call you make. That's why we've created the Client Services Unit (CSU). The CSU is a team of customer service experts who can answer your questions about large groups—those with 51 or more members. The CSU representatives can access your groups' benefits. They've gone through an extensive training program and they're standing by to help you with:

- Claims
- Contract interpretation
- HIPAA and COBRA questions
- Schedule A requests
- Benefit questions
- Facility locations
- Service issues

The CSU is available to all our customers in California. You can contact the CSU by calling **1-866-752-4737** toll free, Monday–Friday, 8 a.m. to 5 p.m., or via e-mail at csu.ca@kp.org.

Personalized Training

HELPFUL HINT

Contact the Client Services Unit (CSU), your account manager, or your account administrative representative to have a billing and eligibility consultant provide personalized training on any of the following:

- This Kaiser Permanente Administrative Handbook for Mid-to-Large Accounts
- Administration of accounts (membership eligibility and reporting)
- Billing processes and tools
- Membership and billing policies and procedures
- Introduction or guidance on using online account services (Customer Account Services)
- Introduction to electronic media reporting

IMPORTANT ADDRESSES AND PHONE NUMBERS

MEMBER SERVICE CALL CENTER

Members can call our Member Service Call Center for answers to questions about the following:

- Benefits
- Claims
- Copayments
- Facilities
- ID cards
- Service issues

The Member Service Call Center can be reached at **1-800-464-4000,** 7 a.m. to 7 p.m., Monday to Friday, 7 a.m. to 3 p.m., Saturday to Sunday, **1-800-777-1370** (TTY for the deaf, hard of hearing, or speech impaired), **1-800-788-0616** (Spanish), or **1-800-757-7585** (Chinese dialects).

CLAIMS ADMINISTRATION DEPARTMENT

Our Claims Administration Department processes claims for emergency care* and out-of-area urgent care received from non–Kaiser Permanente providers. When members have questions about how to file emergency claims or the status of pending claims, they should contact the departments listed below.

Northern California	Southern California
Kaiser Permanente Claims Administration Department P.O. Box 12923 Oakland, CA 94604-2923 Claims and Referrals Member Service **1-800-390-3510**	Kaiser Permanente Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004 Claims and Referrals Member Service **1-800-390-3510**

HELPFUL HINT

To access their individual claims information more quickly, your employees should be prepared to provide their individual claim number or medical record number.

*If members have an emergency medical condition, they should call **911** or go to the nearest hospital.

An emergency medical condition is (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan hospital (or designated hospital) before delivery, or if transfer poses a threat to your (or your unborn child's) health and safety.

ACCOUNTING PROCEDURES

For complete information on accounting procedures, please refer to pages 2-1 through 2-31.

COBRA AND CAL-COBRA PROCEDURES

For complete COBRA information, please refer to pages 4-1 through 4-4.

MEDICARE

For Medicare overview, please refer to page 3-1.

If your employees are enrolled in our Preferred Provider Organization (PPO) plan, a Point-of-Service (POS) plan, or an Out-of-Area (OOA) Indemnity plan, then Section 6 is your source for important addresses and phone numbers, precertification information, accounting procedures, obtaining ID cards, determining your service areas, and interpreting forms you'll receive.*

POS—A CHOICE OF WHERE AND HOW TO ACCESS CARE

With our POS plans, your employees have the flexibility to determine how and where they receive care. They can access our HMO services, Private Healthcare Systems (PHCS Network) providers, as well as any other licensed provider they choose.† Regardless of where employees choose to receive care, they can still participate in all of the value-added programs that are available to Kaiser Permanente members, including disease management programs, which promote greater employee health and productivity. And, employees can bring their prescriptions from non–Kaiser Permanente physicians to our pharmacies to fill their orders at our in-network rates. Some restrictions may apply.

PPO—THE FREEDOM TO ACCESS A NATIONWIDE PREFERRED PROVIDER NETWORK

With our PPO Insurance plan, your employees have access to a broad nationwide network—PHCS Network—without a referral. They can also receive care from any other licensed health care provider in the nation. At the time of enrollment, employees must be offered our HMO plan.

KAISER PERMANENTE HEALTHY SOLUTIONS

A coordinated suite of services provided to Kaiser Permanente members under certain circumstances. The program offers health coaches, health information, health tools, and a health assessment. Kaiser Permanente Healthy Solutions‡ provides health care services for people at every stage of health—from active "health seekers" to those with behavioral risk factors and those with advanced chronic conditions.

OOA—TOTAL FLEXIBILITY FOR YOUR EMPLOYEES WHO LIVE AND WORK OUTSIDE THE KAISER PERMANENTE SERVICE AREAS

With this plan, you can offer Kaiser Permanente coverage to your employees living outside our service areas. When offered with a Kaiser Permanente HMO, POS, or PPO product, the Out-of-Area Indemnity Plan gives your business a single solution for your employees who live and work outside of Kaiser Permanente and the PHCS network service areas.

*Kaiser Foundation Health Plan, Inc. (KFHP) underwrites the HMO plan and the In-Network portion of the Point-of-Service (POS) plans. Kaiser Permanente Insurance Company (KPIC) underwrites the PHCS Network and nonparticipating provider portion of the POS plan, PPO plan, Out-of-Area Indemnity plan, and the KPIC Group Dental plans. KPIC is a subsidiary of KFHP.

†Kaiser Permanente Insurance Company (KPIC) has contracted with PHCS to provide access to hospitals and physicians with a commitment to keeping out-of-pocket costs low through contracted rates.

‡Services under the Healthy Solutions program are value-added services provided by Kaiser Permanente Healthy Solutions, an affiliate of Kaiser Foundation Health Plan, Inc. (KFHP). These services are not in lieu of any of the services covered under the PPO Group Policy. Likewise, utilization of these services does not constitute receipt of benefits under the PPO Group Policy. The Kaiser Permanente PPO plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP.

IMPORTANT ADDRESSES AND PHONE NUMBERS

Kaiser Permanente is available to answer your questions about eligibility, enrollment forms, account change forms, billing, and monthly payments.

Employers call **1-800-554-3099,** Monday through Friday, 8 a.m. to 5 p.m.

Fax applications and account change forms to **(858) 614-3345** (Southern California) or **(858) 614-3344** (Northern California).

If you fax documents, please don't mail the originals.

Membership and payment mailing addresses

	Northern California	Southern California
Mail enrollments, family account changes, and terminations to:	Kaiser Permanente California Service Center P.O. Box 23758 San Diego, CA 92193-3758	Kaiser Permanente California Service Center P.O. Box 23758 San Diego, CA 92193-3758
Mail payments to:	Kaiser Foundation Health Plan, Inc. P.O. Box 60000 File # 73046 San Francisco, CA 94160-3046	Kaiser Foundation Health Plan, Inc. File # 54803 Los Angeles, CA 90074-4803

IMPORTANT ADDRESSES AND PHONE NUMBERS

KPIC ADMINISTRATION AND CUSTOMER SERVICE

You and your employees can call one of the numbers below for answers to questions about their benefits, ID cards, copayments, facility information, claims, service issues, and more.

Subject	Description	Contact information
In-network HMO benefits (POS only)	For questions about Kaiser Permanente HMO benefits.	Kaiser Permanente Member Service Call Center **1-800-464-4000** **1-800-788-0616** (Spanish) **1-800-757-7585** (Chinese dialects) **1-800-777-1370** (TTY) Monday through Friday 7 a.m. to 7 p.m. Saturday and Sunday 7 a.m. to 3 p.m.
Kaiser Permanente ID cards	For questions about your ID cards.	Kaiser Permanente California Service Center (CSC) **1-800-554-3099** Monday through Friday 8 a.m. to 5 p.m.
PHCS Network providers	For information about participating providers, please call PHCS, or visit their Web site at **www.phcs.com/kaiser**	PHCS **1-888-298-7427** (toll free) Monday through Friday 5 a.m. to 5 p.m.
PHCS Network & nonparticipating provider benefits	For questions about benefits, precertification, and/or emergency admissions.	Kaiser Permanente Insurance Company (KPIC) customer service **1-800-788-0710** Monday through Friday 7 a.m. to 7 p.m. Saturday and Sunday 7 a.m. to 3 p.m.
Billing	For questions about your billing statement or contract administration.	CSC **1-800-554-3099** Monday through Friday 8 a.m. to 5 p.m.
Claims	For questions about the status of a claim or where to mail a claim.	KPIC customer service **1-800-788-0710** Monday through Friday 8 a.m. to 5 p.m.
Pharmacy	For questions about pharmacy eligibility benefits, claims, or to locate a MedImpact pharmacy.	MedImpact **1-800-788-2949** Seven days a week 24 hours a day
Precertification	For questions about precertification.	SHPS **1-800-448-9776**

IMPORTANT ADDRESSES AND PHONE NUMBERS

REMINDER

When you or your employees call for information on a specific account, please have both the customer/purchaser account number and member medical record number available.

CLAIMS ADMINISTRATION

To help ensure claims are paid in a timely manner, it is important that your employees use the appropriate address for their claim type.

Medical claims (Non-emergency)

Service	POS	PPO	OOA
N. CAL. and S. CAL.	KPIC P.O. Box 261155 Plano, TX 75026 **(800) 788-0710**	KPIC P.O. Box 261155 Plano, TX 75026 **(800) 788-0710**	KPIC P.O. Box 261155 Plano, TX 75026 **(800) 788-0710**

Medical claims (Emergency)

Service	POS	PPO	OOA
N. CAL.	KFHP Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923 **(800) 788-0710**	KPIC P.O. Box 261155 Plano, TX 75026 **(800) 788-0710**	KPIC P.O. Box 261155 Plano, TX 75026 **(800) 788-0710**
S. CAL.	KFHP Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 **(800) 788-0710**	KPIC P.O. Box 261155 Plano, TX 75026 **(800) 788-0710**	KPIC P.O. Box 261155 Plano, TX 75026 **(800) 788-0710**

For Kaiser Permanente Point-of-Service (POS) members

If a member has an emergency medical condition, he or she should call 911 or go to the nearest hospital. When a member has an emergency medical condition, we cover emergency care from Plan providers and non-Plan providers anywhere in the world.

Examples of symptoms that may require emergency services include, but are not limited to:

- Severe chest or upper abdominal pain accompanied by shortness of breath, sweating, and/or pain radiating from the left arm.
- Severe shortness of breath.
- Sudden decrease or loss of consciousness.
- Sudden inability to talk or move one side of the body.
- Severe, persistent bleeding that can't be stopped.
- Major injuries such as gunshot wounds or severe injuries from a vehicle accident.

The Kaiser Permanente Emergency Claims Administration Department processes claims for emergency services received at non–Kaiser Permanente facilities for our POS members. When your employees have questions about eligible services, how to file emergency claims, or the status of pending emergency claims, they can call **1-800-390-3510.**

IMPORTANT ADDRESSES AND PHONE NUMBERS

Out-of-Plan emergency benefit for POS members

Emergency care means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

1. Placing the covered person's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part

If members have a medical emergency, they should seek treatment at the nearest hospital. However, if they receive treatment at a non–Kaiser Permanente hospital, they or their representative (spouse, child, or other family member) should call us as soon as reasonably possible at **1-800-225-8883** so that we can coordinate care or transfer the member to a Kaiser Permanente hospital, if it is safe to do so. Calling Kaiser Permanente helps ensure that members receive the care and attention they need.

Claims forms for reimbursement consideration must be submitted within 90 days of the emergency services.

Please see page 8-16, Section 8, Sample Statements and Forms, for a copy of the claim form.

An emergency medical condition is (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan hospital (or designated hospital) before delivery, or if transfer poses a threat to your (or your unborn child's) health and safety.

Note: Emergency care is available at Plan hospital Emergency Departments listed in *Your Guidebook to Kaiser Permanente Services*. For ease and continuity of care, we encourage members to go to a Plan hospital Emergency Department, but only if it's reasonable to do so, considering their condition or symptoms. Members should refer to the guidebook for Plan hospital Emergency Departments in their area.

For PPO and Out-of-Area members

Medical emergencies are covered anywhere in the world. If a member has an emergency medical condition, the member or family member should call **911** or go to the nearest hospital or emergency facility. The member, the attending physician, or another responsible person should notify SHPS Healthcare Services Call Center at **1-800-448-9776.** This will allow SHPS to consult with the physician providing the care and to coordinate further medical care if necessary. Professionals are available 24 hours a day, seven days a week. KPIC has partnered with SHPS Healthcare Services, a utilization management organization, to ensure that the medical services the member receives are both appropriate and cost-effective.

IMPORTANT ADDRESSES AND PHONE NUMBERS

ALL OTHER CLAIMS

For all Kaiser Permanente Insurance Company (KPIC) members (i.e., POS, PPO, and Out-of-Area Indemnity) accessing out-of-plan services, PHCS Network and nonparticipating providers may submit their claims directly to KPIC. However, if this doesn't take place, members may submit a KPIC Medical Claims Form to the appropriate address in the grid on page 6-4.

PRECERTIFICATION

To help ensure that the medical services your employees receive is both appropriate and cost-effective, we have partnered with SHPS, Inc., a leader in utilization management.

All patient hospital stays, certain outpatient procedures, and other procedures or services require precertification. The member or their physician must contact SHPS at least three days prior to admission and within 24 hours after emergency care has commenced, or as soon as reasonably possible.

The following treatments or services require precertification:

1. Hospital confinements, including preadmission testing
2. Inpatient care at a skilled nursing facility or any other licensed medical facility
3. Hospice care
4. Home health care services
5. Comprehensive rehabilitation facility
6. Outpatient surgery at a hospital, freestanding surgical facility, or other licensed medical facility
7. The following specific treatments and procedures:

- Inpatient admissions, including comprehensive rehabilitation, long-term care, and sub-acute care
- AICD insertion
- Biventricular pacemaker
- Blepharoplasty
- Breast augmentation
- Breast reduction
- Circumcision, except for newborn infants immediately following delivery
- Cochlear implant
- Colonoscopy
- Craniofacial reconstruction
- Craniotomy
- Cryosurgical ablation of the prostate
- Dental anesthesia
- Endoscopy, wireless pill video
- Enteral solutions
- Epidural injections
- Hemorrhoidectomy
- Hyperbaric oxygen treatment
- Hysteroscopy
- Infertility procedures
- Laparoscopy
- Lithotripsy
- Neuropsychological testing—CPT code 96117
- Occupational therapy (freestanding/home care)
- Orthognathic surgery
- Orthotripsy
- Penile prosthesis insertion
- Prostate seed implants
- PET scans
- Sclerotherapy
- Septoplasty
- Speech therapy (freestanding/home care)
- Sympathectomy
- Transplants
- UPPP (uvulo-palato-pharyngoplasty)
- Uretorolysis
- Uterine artery embolization
- Varicose vein treatment

PRECERTIFICATION

The following durable medical equipment (DME) requires clinical information to determine medical necessity:

- Apnea monitor
- Bone stimulator
- Communicators
- DOC bands/soft shell helmets
- Hearing aid
- Insulin pump
- Lymph edema therapy
- Orthotics/prosthetics
- Ostomy supplies—initial request
- Oxygen therapy (in home)
- Pain management (equipment associated with pain management including implantable devices)
- Penile prosthesis
- Pulse oximeter
- Scoliosis brace
- Soft supplies
- Specialty beds
- Ultrasonic osteogenic stimulator
- Wheelchair/scooter
- Wound VAC

Note: This list is subject to change. Please refer to your *KPIC Certificate of Insurance* for a more comprehensive list of services subject to precertification under the KPIC Group Policy.

If members don't obtain precertification, their benefits may be reduced as described in the *KPIC Certificate of Insurance* even if the treatment or service is deemed to be medically necessary. If the treatment or service is deemed not to be medically necessary, the treatment or service will not be covered at all.

This reduction in benefits will not apply to satisfy any deductible, coinsurance, or out-of-pocket expense.

Note the following precertification requirements:

- The member or the attending physician must notify SHPS **at least three days** prior to the planned hospital confinement or for any other treatments or procedures requiring precertification.
- Notification of an **extension of a hospital confinement** beyond the number of days originally precertified must be given as soon as reasonably possible prior to an extension.
- **Emergency hospital confinement notification** must be given as soon as reasonably possible or within 24 hours after care has commenced.

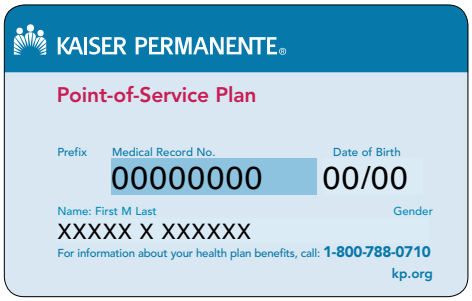
POS members who are taken to a PHCS Network or a non–participating provider hospital for emergency services should call **1-800-225-8883** to maximize their health care coverage.

To obtain precertification from SHPS for PHCS Network and non–participating provider care, please call **1-800-788-0710.**

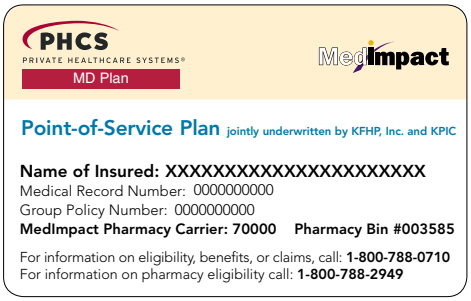
KAISER PERMANENTE MEDICAL/PHARMACY ID CARDS

POS ID CARDS

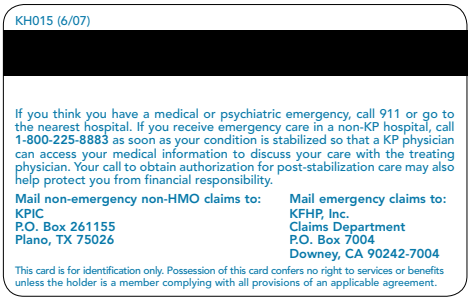
1. Members receive a unique medical record number and two ID cards—one blue and one gold—in a protective card sleeve.
2. They should use the blue card at Kaiser Permanente medical facilities and pharmacies.
3. Members should use the gold card when they visit PHCS Network providers, other licensed providers, and MedImpact network pharmacies.
4. Members who lose one or both of their cards should call KPIC Customer Service right away. Customer Service can also provide details about benefits and coverage.



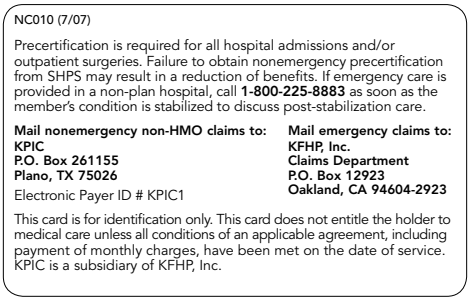
POS (South front)



POS Rx (North front)



POS (South back)



POS Rx (North back)

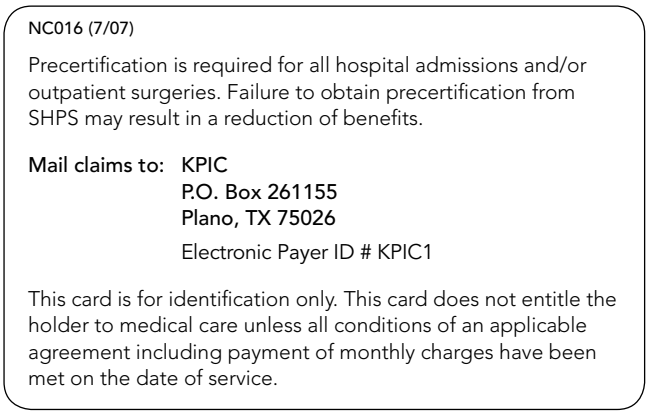
Members should not use either card before their coverage takes effect. If the coverage has not taken effect, they'll be responsible for the full cost of any services they receive. Likewise, if their coverage has terminated, they'll be responsible for any services they receive. Members must always present their ID card when they go to get care.

KAISER PERMANENTE MEDICAL/PHARMACY ID CARDS

PPO ID CARDS

- Members receive a unique medical record number and one gold ID card.
- Members should use the card when they visit PHCS Network providers, other licensed providers, and MedImpact network pharmacies.
- Members who lose their card should call KPIC Customer Service right away. Customer Service can also provide details about benefits and coverage.

PPO Rx (North front)



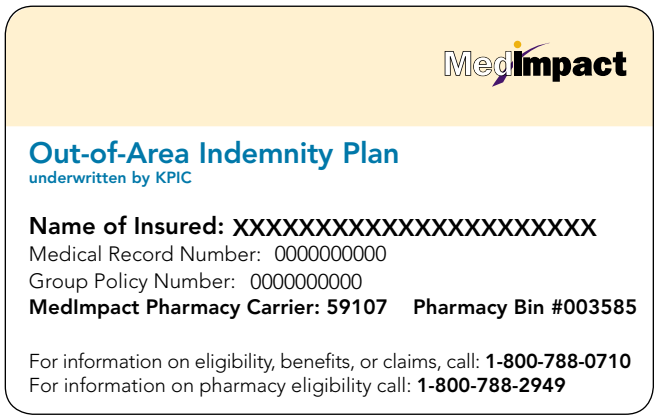
PPO Rx (North back)

Members should not use their card before their coverage takes effect. If the coverage has not taken effect, they'll be responsible for the full cost of any services they receive. Likewise, if their coverage has terminated, they'll be responsible for any services they receive. Members must always present their ID card when they go to get care.

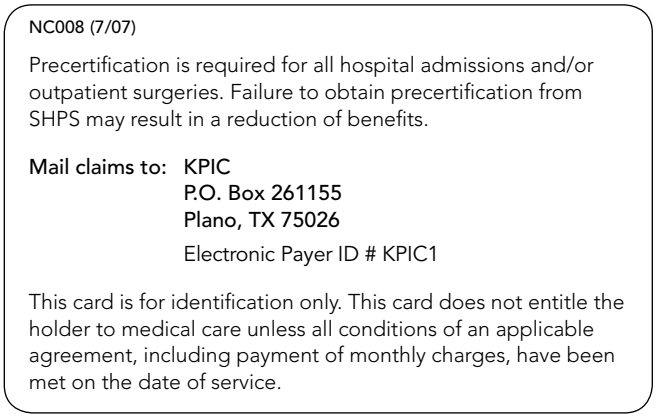
KAISER PERMANENTE MEDICAL/PHARMACY ID CARDS

OUT-OF-AREA ID CARDS

- Members receive a unique medical record number and one gold ID card.
- Members should use their ID card when they visit any licensed medical provider or MedImpact network pharmacies.
- Members who lose their card should call KPIC Customer Service right away. Customer Service can also provide details about benefits and coverage.



OOA Rx (North front)

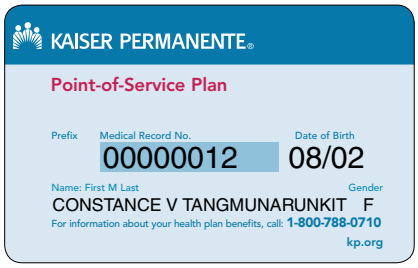


OOA Rx (North back)

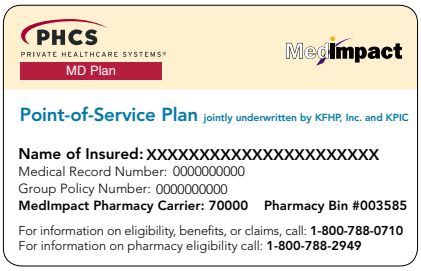
Members should not use their card before their coverage takes effect. If the coverage has not taken effect, they'll be responsible for the full cost of any services they receive. Likewise, if their coverage has terminated, they'll be responsible for any services they receive. Members must always present their ID card when they go to get care.

KAISER PERMANENTE MEDICAL/PHARMACY ID CARDS

The following information is supplied on the card sleeve when a member receives a new Kaiser Permanente ID card:



Please present this card when accessing services at a Kaiser Permanente medical facility, hospital, or pharmacy.



Please present this card when accessing services from a non–Kaiser Permanente provider and/or pharmacy.

ARBITRATION LANGUAGE* AND FORM APPROVAL

Q: How much time does Kaiser Permanente need to review and approve forms or text?

A: Customers should allow adequate lead time for review and approval. Documents that are submitted simultaneously to Health Plan Regulatory Services and the CSC require an average of three business days for Health Plan review and comment. Revised documents submitted for approval will also typically be reviewed within three business days.

Q: How often are customer-produced forms and text reviewed?

A: In order to stay current with any changes in the law, Health Plan reviews all customer-produced forms as well as IVR and electronic enrollment text annually as part of the customer's renewal process.

Q: Who do we ask?

A: Direct any questions about the inclusion of binding arbitration notification text as part of your enrollment process to your account manager or account administration representatives (AAR).

Q: Can we obtain more information about California Health and Safety Code Section 1363.1?

A: California laws governing use of binding arbitration by health care service plans include specific requirements for notifying customers and enrollees.

California Health and Safety Code Section 1363.1 provides in relevant part:

Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:

a. The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.

b. The disclosure shall appear as a separate article in the agreement issued to the customer or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.

c. The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.

d. In a contract or enrollment agreement for a health care service plan, the disclosure required by this section shall be displayed immediately before the signature line provided for the representative of the customer contracting with a health care service plan and immediately before the signature line provided for the individual enrolling in the health care service plan.

*Kaiser Foundation Health Plan (KFHP) Arbitration Agreement (applies to KFHP only; does not apply to Kaiser Permanente Insurance Company products).

PHCS NETWORK AND ONLINE ACCOUNT SERVICES

This statute dictates that use of binding arbitration must be disclosed on enrollment forms to ensure that prospective subscribers know of the arbitration requirement before they enroll.

PHCS NETWORK

Q: What can my employees do if their provider isn't in PHCS Network?

A: Members can nominate providers for membership with PHCS by completing the online provider referral request at **www.phcs.com/kaiser**. The online provider referral system provides updates via e-mail to members who have nominated their physician. You can also contact your Kaiser Permanente account representative, who will contact PHCS Network on your behalf. The credentialing process can take three to six months.

Q: How are claims handled by PHCS Network?

A: You and your employees don't have any additional administrative responsibilities with PHCS Network. In most cases, providers in PHCS Network submit claims directly to Kaiser Permanente. Copayments, if applicable, are due at the time of the office visit.

Q: Who should my employees contact with questions about claims?

A: Members should contact Kaiser Permanente Insurance Company's customer service line at **1-800-788-0710** with their questions.

Q: How does using PHCS Network affect my employees living outside California?

A: All employees enrolled in a KPIC POS or PPO plan can access PHCS Network. Nationwide, nearly 450,000 providers participate in PHCS Network. Employees can check to see if their doctor participates in PHCS Network at **www.phcs.com/kaiser** or by calling PHCS Network toll free at **1-888-298-7427.**

ONLINE ACCOUNT SERVICES

Q: What are online account services?

A: Our online account services are developed specifically to help employers manage their Kaiser Permanente health plan accounts. These services allow you to:

- Add or terminate employee and dependent memberships.
- Change employee and dependent demographic information.
- View a list of subscribers and their covered dependents.
- View your balance due.
- View transaction history.
- View your monthly bill.
- Pay your bill.

Q: Are these services free?

A: Yes.

Q: How can I sign up for online account services?

A: To sign up, visit our online account services at **kp.org/ouremployers**.

- If you're currently offering Kaiser Permanente coverage, select your region and click on **Continue.**
- Click on **Manage your account** and then select **Preview account services** from the drop-down menu. Next, click on **Take our tour.**
- By taking our tour, you can preview our account services. At the end of the tour, you can download a user ID request form and fax it to us. You should receive a user ID and password in the mail within seven business days to begin using the service. Please note that you must list yourself as the "Requester" on the form. For security purposes, we will only mail the user ID and password to you.

Q: Can I still file membership via electronic transfer?

A: Yes. In fact, we encourage it. Filing electronically is a great way to go. However, the online functions will benefit you by:

- Providing a quick way to get the status of your account without making a phone call.
- Allowing you to work according to your schedule, rather than Kaiser Permanente's service hours.

Q: Will I still receive a paper bill?

A: Yes, you'll continue to receive a paper bill.

Q: Do I have to use the Internet for everything?

A: No. We're offering you the use of the Internet as an added convenient way to work with us, because we think it'll make the administration of your Kaiser Permanente health plan easier. You can think of these online services as a "health plan ATM" that provides you with faster service. You still have an assigned account administration representative whom you can call at any time for one-on-one customer service.

Q: Can I enter new enrollments online?

A: Yes. You can enter new enrollments, provided that the customer handles the enrollments as prescribed by the online enrollment guidelines. This means that the customer retains all completed and signed enrollment forms or proof of enrollment if a telephonic interactive voice response (IVR) or electronic/Web site or online enrollment process is used.

The customer retains such enrollment documentation for future reference if there is a question as to who enrolled when or whether or not the customer's enrollment form or process provided notice about Kaiser Permanente's use of binding arbitration at the point of enrollment as prescribed by California law. Terminations may also be handled online. For changes outside the allowed time frame, please contact your account administration representative or refer to the Retroactivity section on page 2-10.

Q: Will this online service handle Medicare and COBRA enrollments for my employees?

A: COBRA enrollments can be processed using online account services. For Medicare enrollments, please contact your Kaiser Permanente group representative for more information on Kaiser Permanente Senior Advantage enrollments.

Q: How do I know which former employees and dependents are currently enrolled in COBRA or Cal-COBRA?

A: If you have a COBRA billing unit where you are responsible for billing the member, you may see your COBRA members.

- Go under the billing unit on your account and select the "Subscriber List" function under "Member Functions." If you have COBRA or Cal-COBRA in which Kaiser Permanente is responsible for the billing, this is not an option because these accounts don't have a group billing unit and are billed directly to the member by Kaiser Permanente.
- To obtain a list of members enrolled in COBRA or Cal-COBRA where Kaiser Permanente is responsible for the billing, contact your account manager.

Q: Will my employees have access to the service?

A: No. This service is designed for you to manage your group's health plan accounts online. However, your employees who have selected Kaiser Permanente as their health plan can use our member Web site at **kp.org** to:

- Request appointments.
- Use the health and drug encyclopedias.
- Access other useful features and services to help them manage their and their families' health care.

Q: Can I have an additional user ID for another person in my office?

A: Absolutely. Kaiser Permanente will provide you with one user ID. Your user ID gives you "administrator" privileges. It allows you to create additional user IDs for those you wish to access the site and vary their privileges according to their responsibilities. (You'll find this function under the "Account Access" drop-down menu within the Web site.)

Q: Is this a secure Web site?

A: Yes. Our Web site is protected by data firewalls and several leading antivirus software products, making external access extremely difficult. Our data centers are high-security facilities monitored around the clock to prevent unauthorized access. Data center visitors must have an appointment, a valid ID, and an internal escort. We also have internal and external auditors and compliance officers routinely evaluate the performance of technical controls in our data-processing centers.

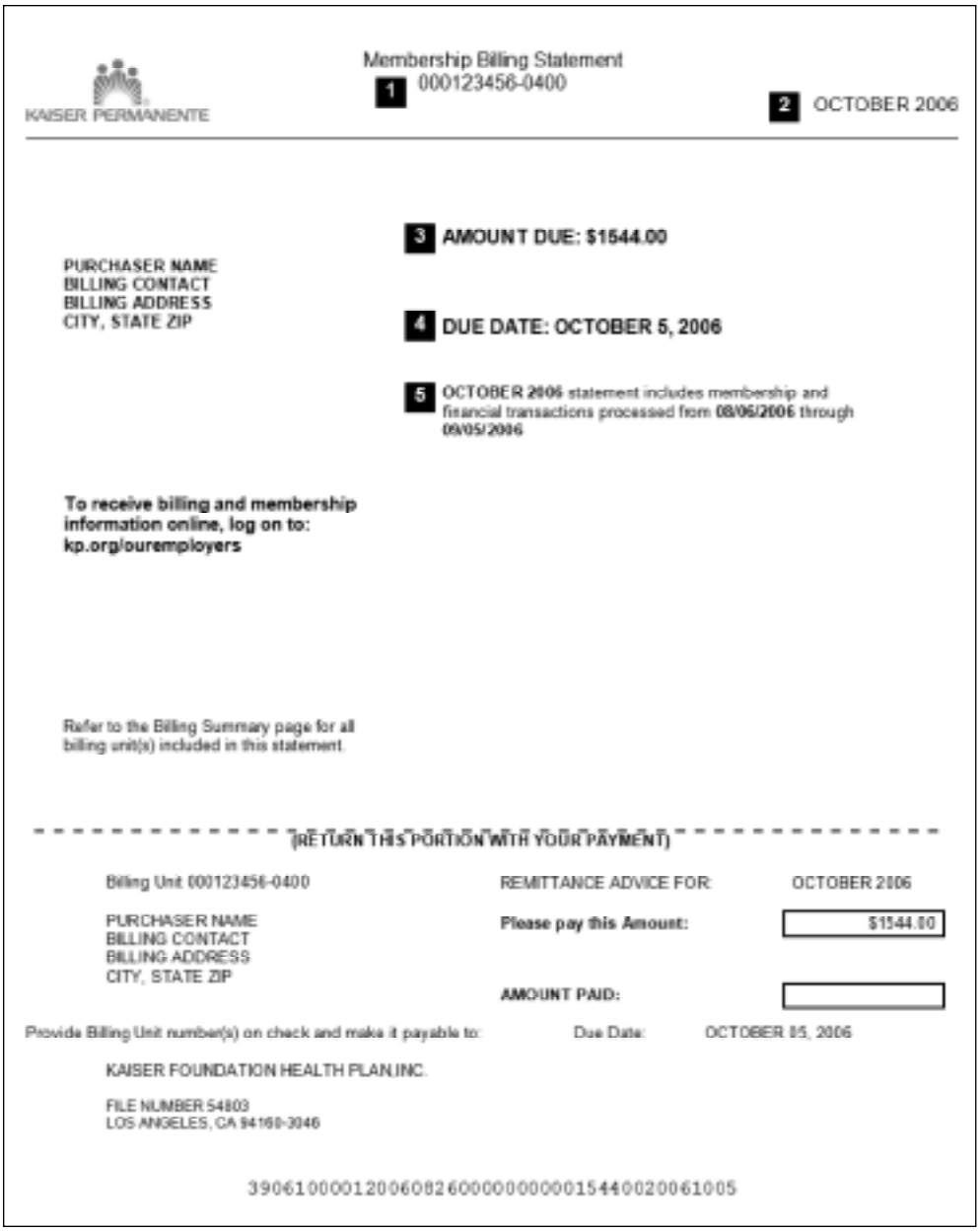
SECTION 8—Sample Statements and Forms

This section contains sample statements and forms that are available to you through your account manager. The table below indicates the audience for each statement or form.

Form name	For MTL HMO/DHMO accounts	For KPIC accounts
Billing Statements		
Membership Billing Statement	X	X
Billing Summary	X	X
Billing Detail/Payments Detail	X	X
Billing Detail/Adjustments	X	X
Billing Detail/Membership Activity Detail	X	X
Billing Detail/Current Dues	X	X
Billing Detail/Membership Current Dues	X	X
Current Dues Summary	X	X
Reconciliation Discrepancy Report	X	
Reconciliation Summary in the Discrepancy Report	X	
Reconciliation Current Roster Report by Account Name	X	
Reconciliation Membership Summary by Contract Option	X	
Reconciliation Discrepancy Report by Contract Option	X	
Cumulative Reconciliation Discrepancy Report—Totals	X	
Cumulative Reconciliation Discrepancy Report—Subscriber Totals	X	
California Region Group Enrollment/Change Form	X	
Student Certification form (in English and Spanish)	X	X
Subscriber Termination and Transfer Form	X	
COBRA Enrollment Form	X	X
KPIC's Enrollment/Account Change Form		X
KPIC Medical Claim Form		X
Direct Member Reimbursement Prescription Claim Form		X

BILLING STATEMENTS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

Membership Billing Statement



KAISER PERMANENTE

Membership Billing Statement
1 000123456-0400

2 OCTOBER 2006

3 **AMOUNT DUE: $1544.00**

PURCHASER NAME
BILLING CONTACT
BILLING ADDRESS
CITY, STATE ZIP

4 **DUE DATE: OCTOBER 5, 2006**

5 OCTOBER 2006 statement includes membership and financial transactions processed from **08/06/2006** through **09/05/2006**

To receive billing and membership information online, log on to: kp.org/ouremployers

Refer to the Billing Summary page for all billing unit(s) included in this statement.

(RETURN THIS PORTION WITH YOUR PAYMENT)

Billing Unit 000123456-0400

PURCHASER NAME
BILLING CONTACT
BILLING ADDRESS
CITY, STATE ZIP

REMITTANCE ADVICE FOR: OCTOBER 2006

Please pay this Amount: $1544.00

AMOUNT PAID:

Provide Billing Unit number(s) on check and make it payable to:

Due Date: OCTOBER 05, 2006

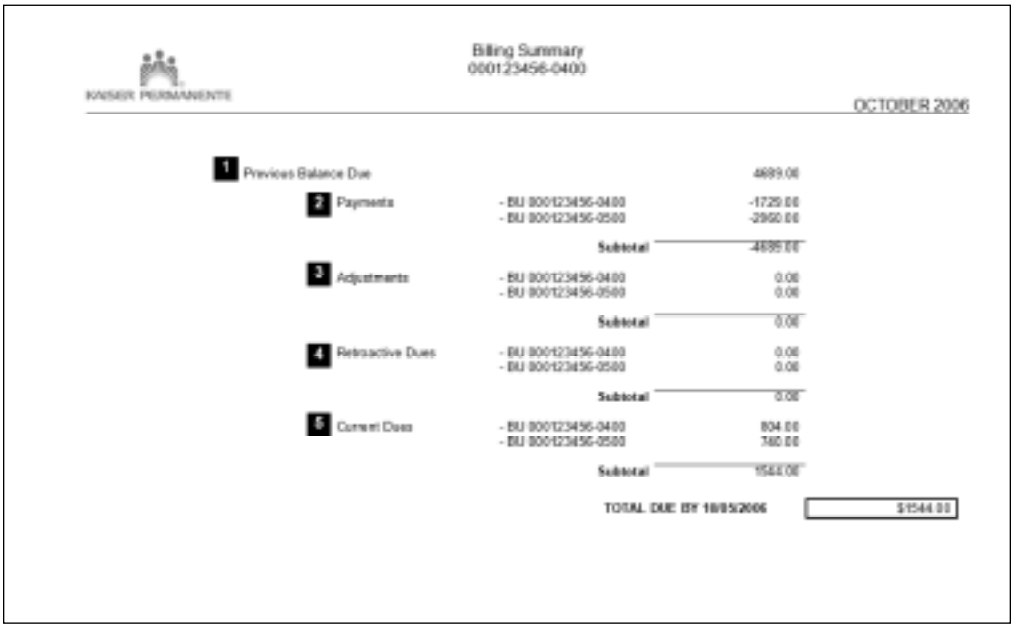
KAISER FOUNDATION HEALTH PLAN,INC.

FILE NUMBER 54803
LOS ANGELES, CA 94160-3046

3906100001200608260000000000154400 20061005

BILLING STATEMENTS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

Billing Summary



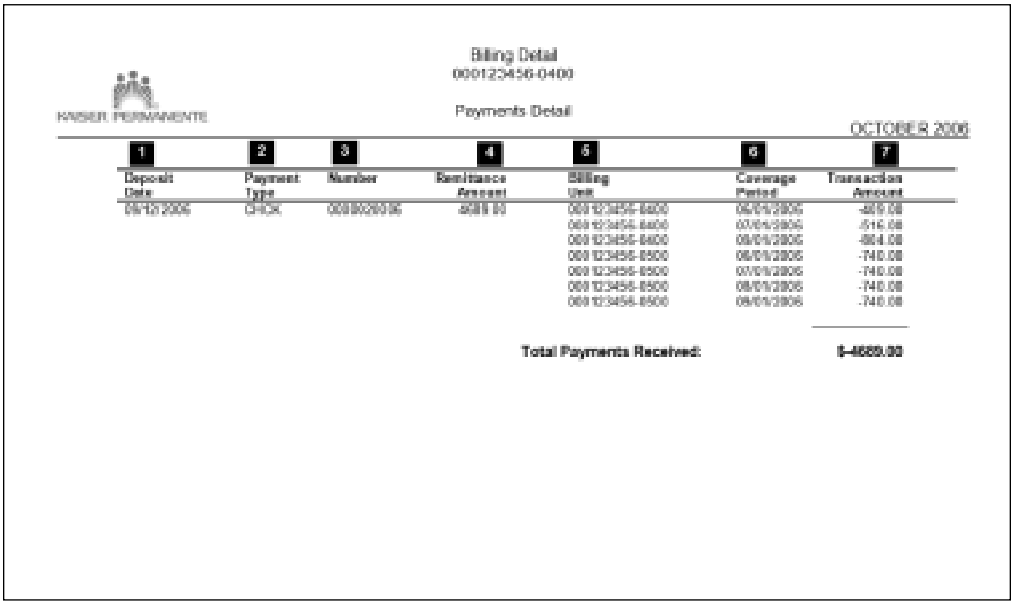
Billing Summary
000123456-0400

KAISER PERMANENTE

OCTOBER 2006

1	Previous Balance Due		4689.00
2	Payments	- BU 000123456-0400	-1729.00
		- BU 000123456-0500	-2960.00
		Subtotal	-4689.00
3	Adjustments	- BU 000123456-0400	0.00
		- BU 000123456-0500	0.00
		Subtotal	0.00
4	Retroactive Dues	- BU 000123456-0400	0.00
		- BU 000123456-0500	0.00
		Subtotal	0.00
5	Current Dues	- BU 000123456-0400	804.00
		- BU 000123456-0500	740.00
		Subtotal	1544.00
	TOTAL DUE BY 10/05/2006		$1544.00

Billing Detail/Payments Detail



Billing Detail
000123456-0400

KAISER PERMANENTE

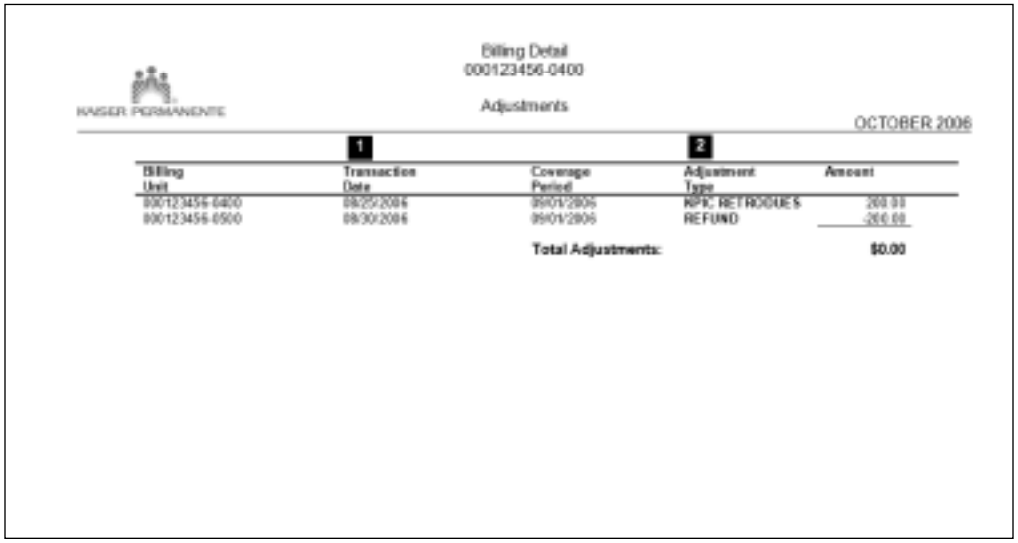
Payments Detail

OCTOBER 2006

1 Deposit Date	2 Payment Type	3 Number	4 Remittance Amount	5 Billing Unit	6 Coverage Period	7 Transaction Amount
09/12/2006	CHCK	0000020036	4689.00	000123456-0400	08/01/2006	-804.00
				000123456-0400	07/01/2006	-516.00
				000123456-0400	08/01/2006	-804.00
				000123456-0500	08/01/2006	-740.00
				000123456-0500	07/01/2006	-740.00
				000123456-0500	08/01/2006	-740.00
				000123456-0500	09/01/2006	-740.00
				Total Payments Received:		$-4689.00

BILLING STATEMENTS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

Billing Detail/Adjustments



Billing Detail
000123456-0400

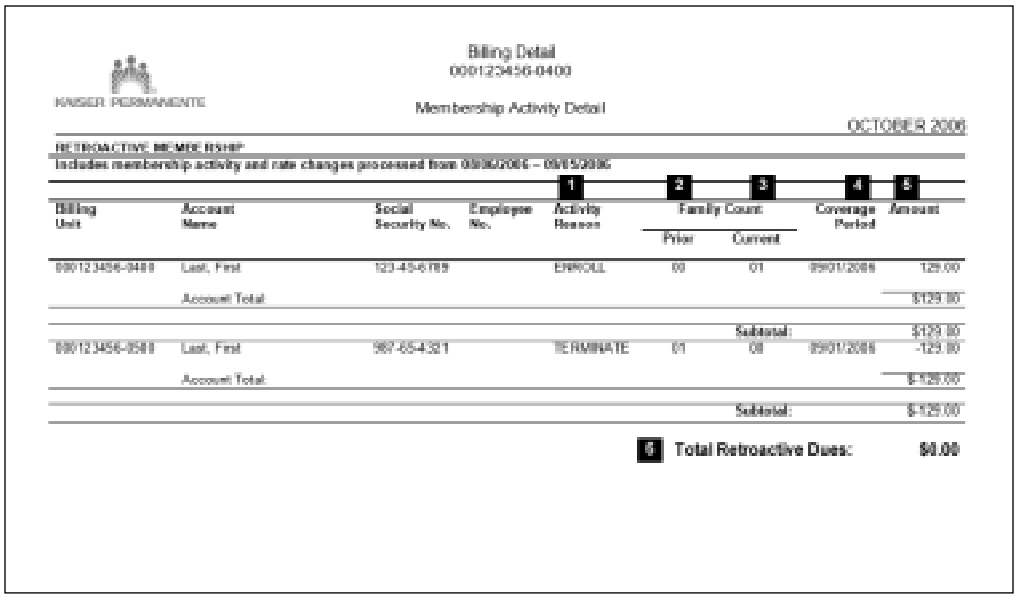
KAISER PERMANENTE

Adjustments

OCTOBER 2006

Billing Unit	1 Transaction Date	Coverage Period	2 Adjustment Type	Amount
000123456-0400	08/25/2006	09/01/2006	KPIC RETRODUES	200.00
000123456-0500	08/30/2006	09/01/2006	REFUND	-200.00
		Total Adjustments:		$0.00

Billing Detail/Membership Activity Detail



Billing Detail
000123456-0400

KAISER PERMANENTE

Membership Activity Detail

OCTOBER 2006

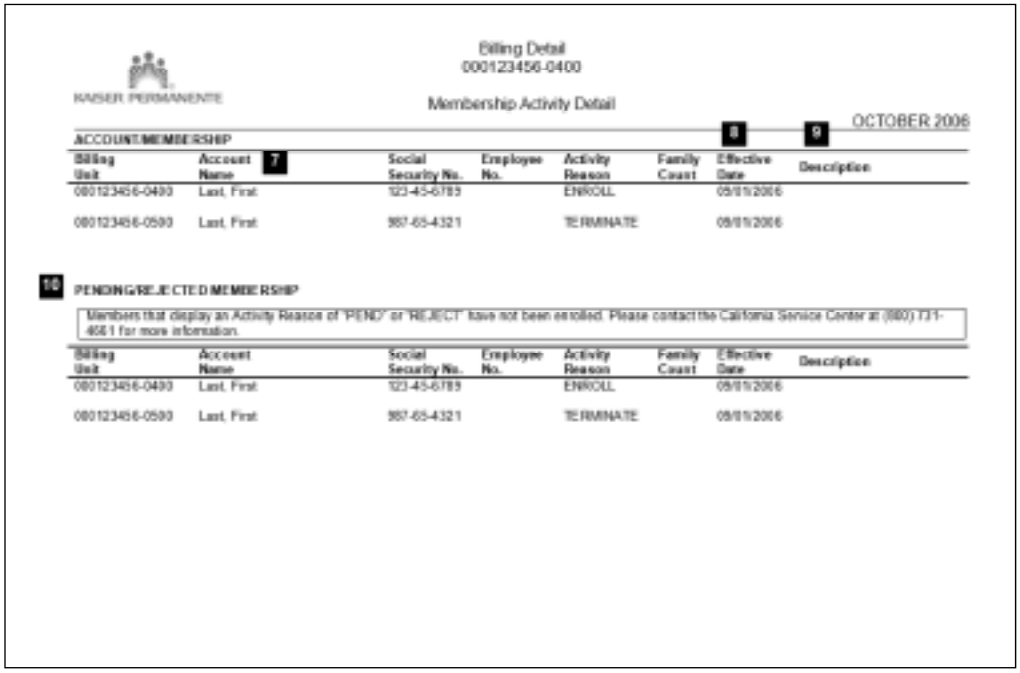
RETROACTIVE MEMBERSHIP

Includes membership activity and rate changes processed from 09/30/2006 – 09/15/2006

Billing Unit	Account Name	Social Security No.	Employee No.	1 Activity Reason	2 Family Count: Prior	3 Current	4 Coverage Period	5 Amount
000123456-0400	Last, First	123-45-6789		ENROLL	00	01	09/01/2006	129.00
	Account Total:							$129.00
						Subtotal:		$129.00
000123456-0500	Last, First	987-65-4321		TERMINATE	01	00	09/01/2006	-129.00
	Account Total:							$-129.00
						Subtotal:		$-129.00
					6 Total Retroactive Dues:			$0.00

BILLING STATEMENTS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

Billing Detail/Membership Activity Detail *(continued)*



KAISER PERMANENTE

Billing Detail
000123456-0400

Membership Activity Detail

OCTOBER 2006

ACCOUNT MEMBERSHIP

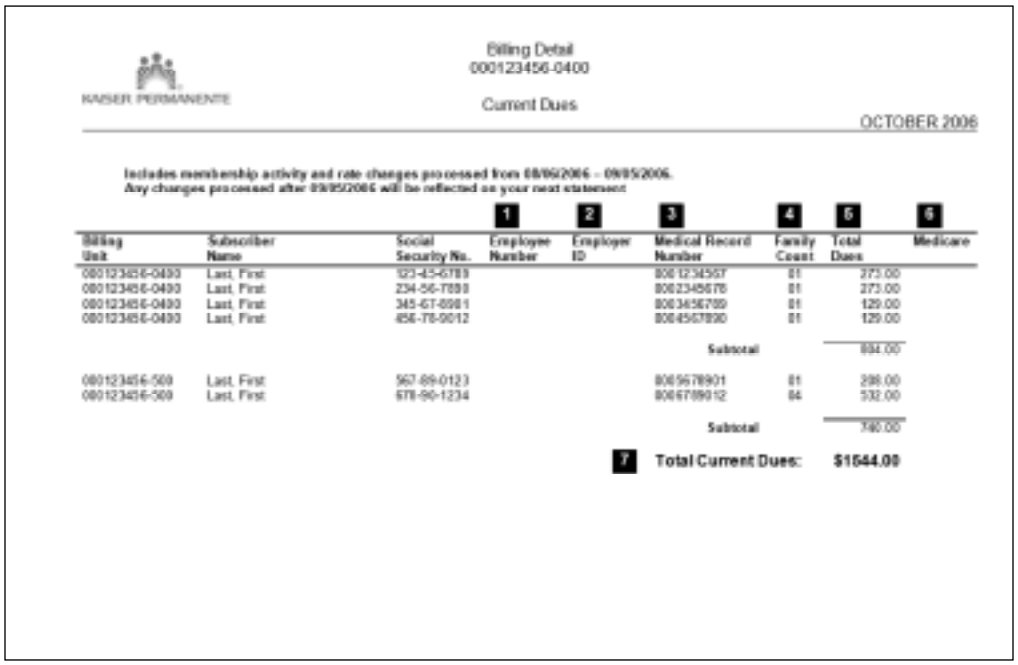
Billing Unit	Account Name	Social Security No.	Employee No.	Activity Reason	Family Count	Effective Date	Description
000123456-0400	Last, First	123-45-6789		ENROLL		09/01/2006	
000123456-0500	Last, First	987-65-4321		TERMINATE		09/01/2006	

PENDING/REJECTED MEMBERSHIP

Members that display an Activity Reason of "PEND" or "REJECT" have not been enrolled. Please contact the California Service Center at (800) 731-4661 for more information.

Billing Unit	Account Name	Social Security No.	Employee No.	Activity Reason	Family Count	Effective Date	Description
000123456-0400	Last, First	123-45-6789		ENROLL		09/01/2006	
000123456-0500	Last, First	987-65-4321		TERMINATE		09/01/2006	

Billing Detail/Current Dues



KAISER PERMANENTE

Billing Detail
000123456-0400

Current Dues

OCTOBER 2006

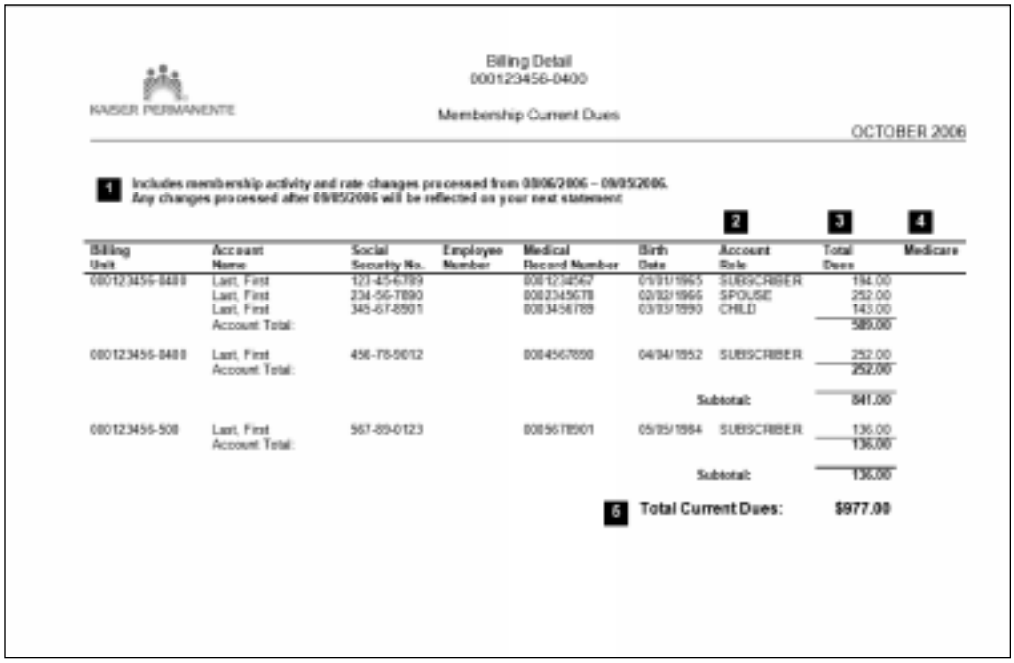
Includes membership activity and rate changes processed from 08/06/2006 – 09/05/2006.
Any changes processed after 09/05/2006 will be reflected on your next statement.

Billing Unit	Subscriber Name	Social Security No.	1 Employee Number	2 Employer ID	3 Medical Record Number	4 Family Count	5 Total Dues	6 Medicare
000123456-0400	Last, First	123-45-6789			8001234567	01	273.00	
000123456-0400	Last, First	234-56-7890			8002345678	01	273.00	
000123456-0400	Last, First	345-67-8901			8003456789	01	129.00	
000123456-0400	Last, First	456-78-9012			8004567890	01	129.00	
					Subtotal		804.00	
000123456-500	Last, First	567-89-0123			8005678901	01	398.00	
000123456-500	Last, First	678-90-1234			8006789012	04	532.00	
					Subtotal		740.00	

7 Total Current Dues: $1544.00

BILLING STATEMENTS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

Billing Detail/Membership Current Dues



KAISER PERMANENTE

Billing Detail
000123456-0400

Membership Current Dues

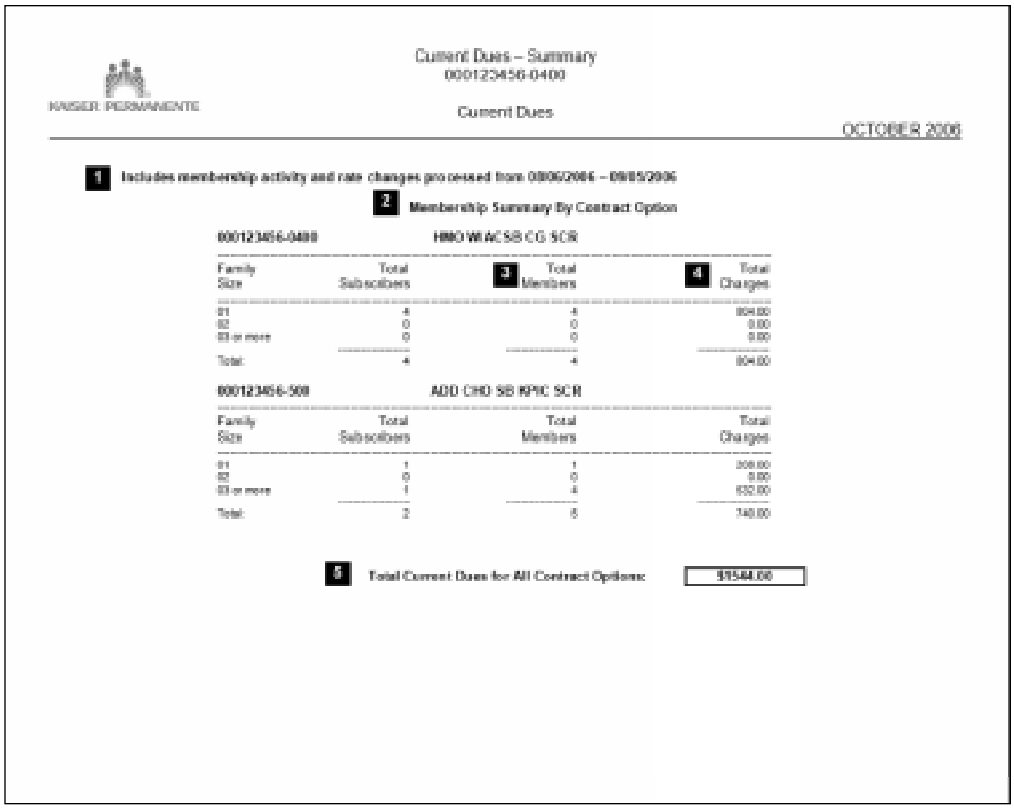
OCTOBER 2006

1 Includes membership activity and rate changes processed from 09/06/2006 – 09/05/2006. Any changes processed after 09/05/2006 will be reflected on your next statement

Billing Unit	Account Name	Social Security No.	Employee Number	Medical Record Number	Birth Date	2 Account Role	3 Total Dues	4 Medicare
000123456-0400	Last, First	123-45-6789		008123456Z	01/01/1965	SUBSCRIBER	194.00	
	Last, First	234-56-7890		008234567B	02/02/1966	SPOUSE	252.00	
	Last, First	345-67-8901		008345678B	03/03/1990	CHILD	143.00	
	Account Total:						589.00	
000123456-0480	Last, First	456-78-9012		008456789B	04/04/1952	SUBSCRIBER	252.00	
	Account Total:						252.00	
						Subtotal:	841.00	
000123456-508	Last, First	567-89-0123		008567890I	05/05/1984	SUBSCRIBER	136.00	
	Account Total:						136.00	
						Subtotal:	136.00	

5 Total Current Dues: $977.00

Current Dues Summary



KAISER PERMANENTE

Current Dues – Summary
000123456-0400

Current Dues

OCTOBER 2006

1 Includes membership activity and rate changes processed from 09/06/2006 – 09/05/2006

2 Membership Summary By Contract Option

000123456-0480 HMO W/ ACSB CG SCR

Family Size	Total Subscribers	3 Total Members	4 Total Charges
01	4	4	804.00
02	0	0	0.00
03 or more	0	0	0.00
Total:	4	4	804.00

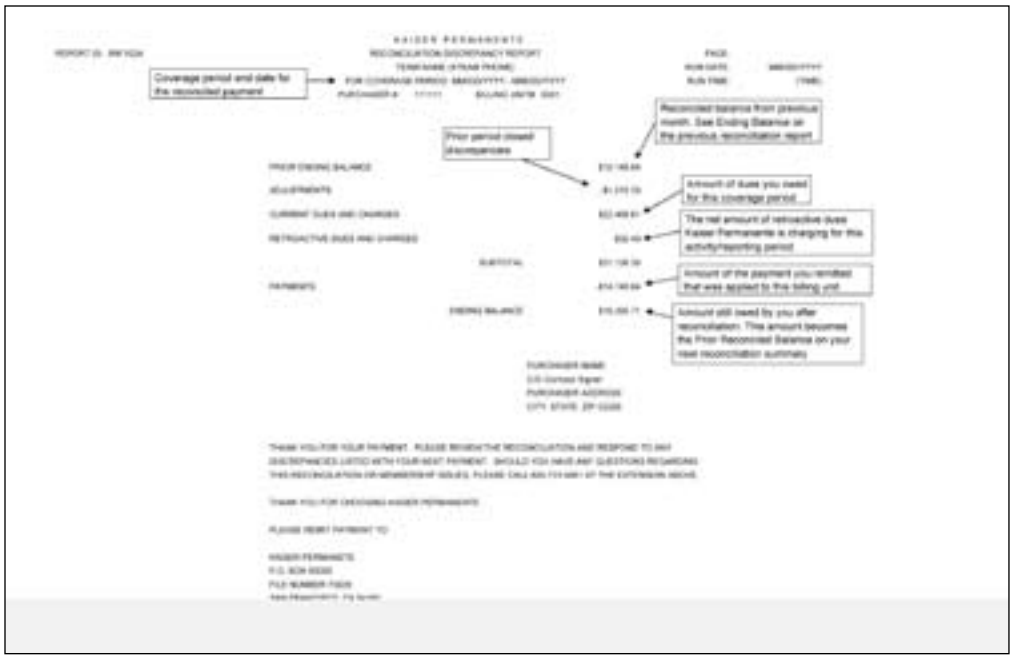
000123456-508 ADD CHD SB KPIC SCR

Family Size	Total Subscribers	Total Members	Total Charges
01	1	1	209.00
02	0	0	0.00
03 or more	1	4	932.00
Total:	2	5	140.00

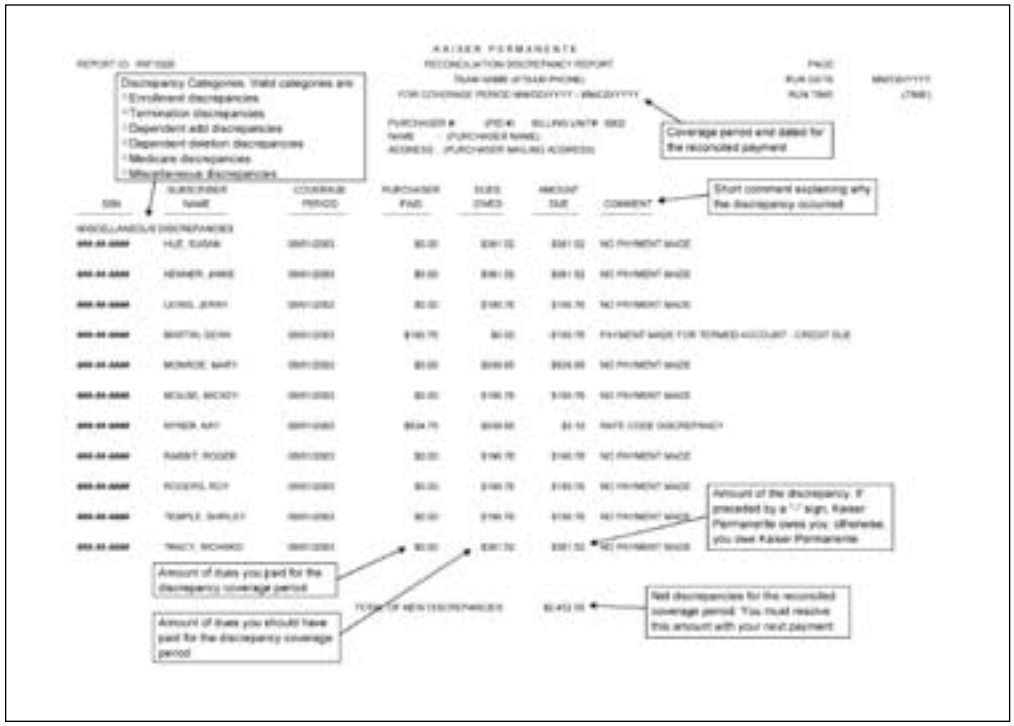
5 Total Current Dues for All Contract Options: $1544.00

BILLING STATEMENTS (FOR MTL HMO/ DHMO ACCOUNTS)

Reconciliation Discrepancy Report (electronic media and self-reporting customers)

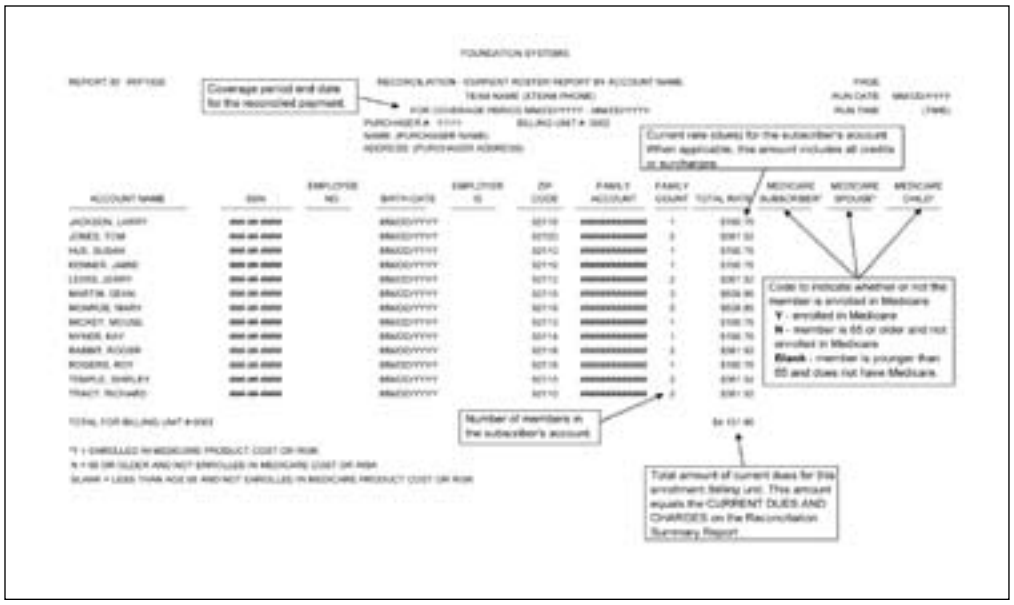


Reconciliation Summary in the Discrepancy Report

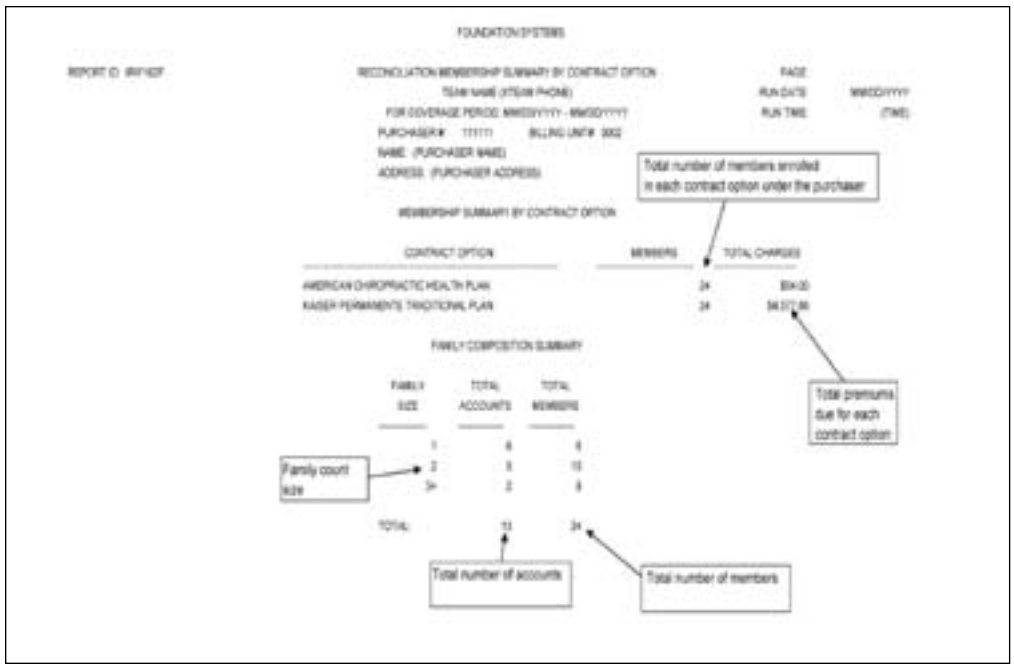


BILLING STATEMENTS (FOR MTL HMO/ DHMO ACCOUNTS)

Reconciliation Current Roster Report by Account Name

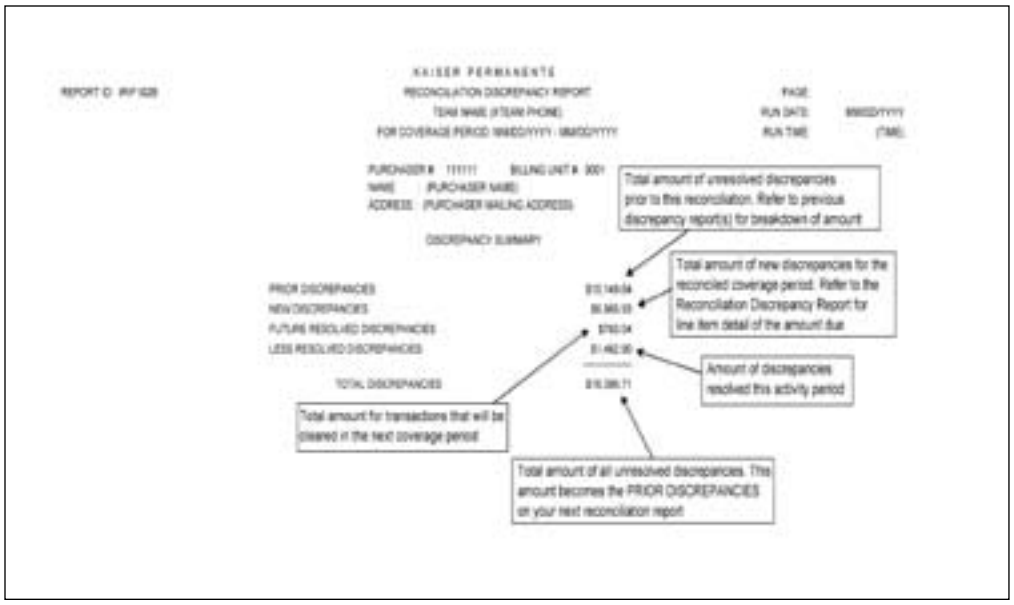


Reconciliation Membership Summary by Contract Option

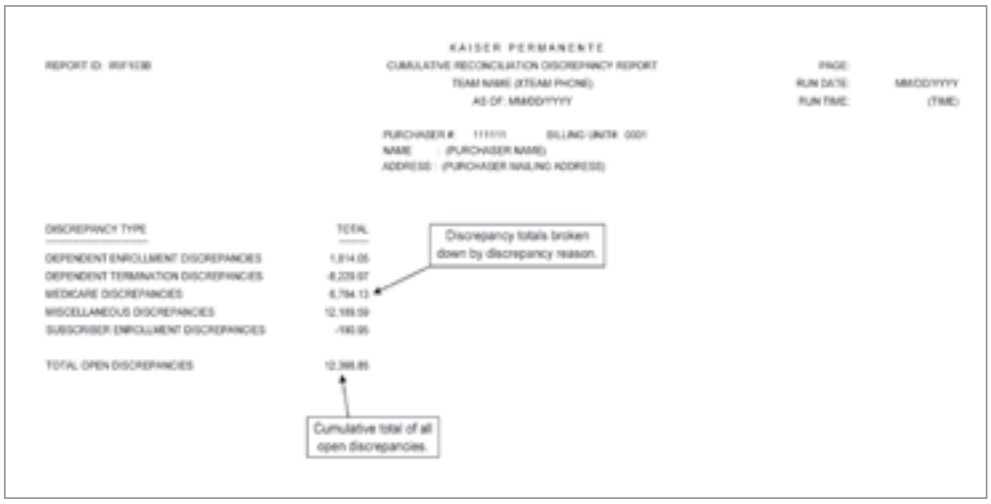


BILLING STATEMENTS (FOR MTL HMO/ DHMO ACCOUNTS)

Reconciliation Discrepancy Report by Contract Option

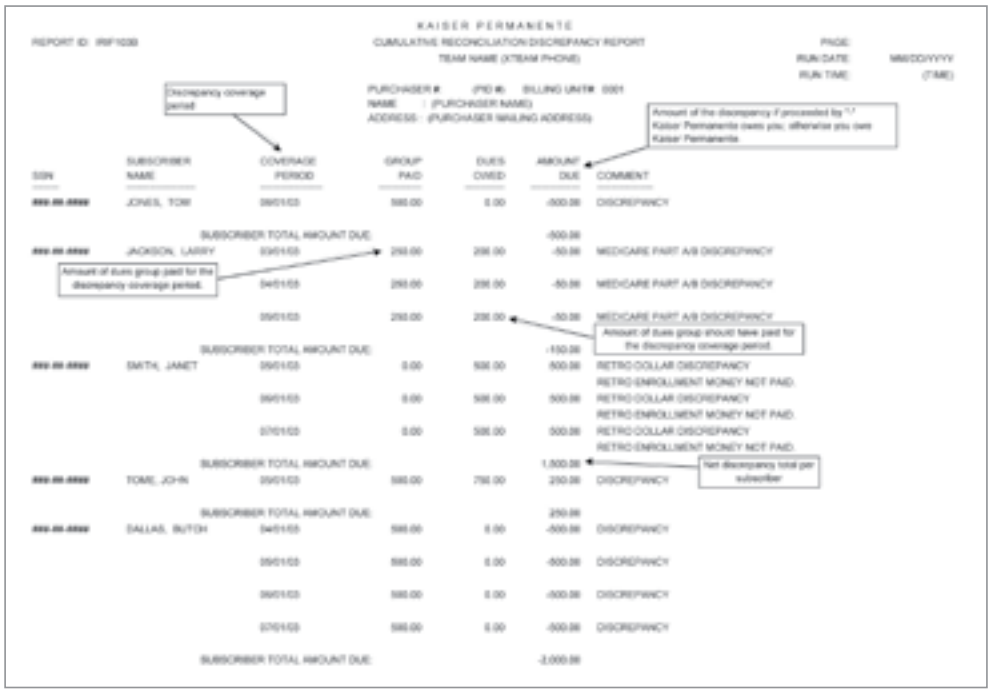


Cumulative Reconciliation Discrepancy Report—Totals



BILLING STATEMENTS (FOR MTL HMO/ DHMO ACCOUNTS)

Cumulative Reconciliation Discrepancy Report—Subscriber Totals



BILLING STATEMENTS (FOR MTL HMO/ DHMO ACCOUNTS)

California Region Group Enrollment/Change Form

KAISER PERMANENTE®

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse *before* completing this form. Retain last copy for your records and use as a temporary ID after the effective date. (See * footnote on reverse.)

TO BE COMPLETED BY EMPLOYER

Company name		Hire date (mm/dd/yyyy)
Group number	Enrollment unit	Effective enrollment or coverage date (mm/dd/yyyy)

NEW ENROLLMENT *Check one:*

❑ New hire *(complete sections A, B, C, D)*
❑ Open enrollment *(complete sections A, B, C, D)*
❑ New group
❑ Other coverage loss *(complete sections A, B, C, D)*
❑ Other *(please specify)* ______________________________
Event date (mm/dd/yyyy) ______________________________

PLAN *Check one:* ❑ HMO ❑ Deductible Plan ❑ Other ______________________________

IF MAKING A CHANGE, COMPLETE THE FOLLOWING:

❑ **Add** dependents *(complete sections A, B, D)* ❑ **Delete** dependents *(complete sections A, B, D)*
*Reason: *(see Change Table)* Event date (mm/dd/yyyy)
❑ **Name change** *(complete sections A, B, D)* From: ______________________ To: ______________________
❑ **Address change** *(complete section A)* ❑ **Telephone change** *(complete section A)*

A. EMPLOYEE

Medical record no. *(if known)*		Social Security no.		
Name **(Last, First, MI)**		Birth date (mm/dd/yyyy)	Gender ❑ M ❑ F	
Home address	Apt. no.	City	State	ZIP
Work phone	Home phone	E-mail		
Preferred spoken or written language		Ethnicity		

B. FAMILY For additional dependents, attach a separate sheet with employee's name at top. **(Last, First, MI)**

❑ Add ❑ Delete	❑ Spouse ❑ Domestic partner	Gender ❑ M ❑ F	Social Security no.
Spouse/Domestic partner name:			Birth date (mm/dd/yyyy)
Former last name *(if any)*:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.
❑ Add ❑ Delete	❑ Child ❑ Student	Gender ❑ M ❑ F	Social Security no.
Dependent name:			Birth date (mm/dd/yyyy)
Relationship:			Medical record no.

Do any of dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:
Name **(Last, First, MI)**: Address:

C. OTHER COVERAGE Including yourself, do any of the persons listed above have other coverage? ❑ Yes ❑ No

Name	Insurance carrier name		Policy no./Effective date	Phone no.

D. Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Employee/Applicant signature	Date	Employer signature	Date

*Additional documentation may be required.

White copy – Kaiser Permanente **Yellow copy – Employer** **Pink copy – Employee**

BILLING STATEMENTS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

Student Certification form (in English and Spanish)

Student Certification

Requirements for dependent student coverage:

- Must be enrolled in an accredited institution.
- Must be dependent upon subscriber for support.
- Must be unmarried.
- Units required are determined by the employer.
- Age limitations are determined by the employer.

I certify that the dependent shown meets all of the requirements for coverage on my account as a full-time student. I understand the Health Plan coverage for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

Dependent's name | Dependent's Medical Record Number

Birth date | Dependent's Social Security number

School name

School address | City, State, ZIP

Student ID number | Number of units carried

Subscriber's name | Subscriber's Medical Record Number

Purchaser ID

X
Subscriber's signature

Social Security number | Date

Employee: Return completed form to your employer; or, if you received this form with a cover letter, please return form in the enclosed business return envelope.

Employer: If Kaiser Permanente certifies your students, return this form to your membership document address.

Certificación de Estudiante

Requisitos para la cobertura de dependientes que son *estudiantes:*

- Debe estar inscrito en una escuela acreditada.
- Debe ser dependiente del suscriptor para su apoyo económico.
- Debe ser soltero.
- El empleador decide los créditos requeridos.
- El empleador decide el límite de edad.

Certifico que dicho dependiente cumple con todos los requisitos para la cobertura en mi cuenta como estudiante de tiempo completo. Entiendo que la cobertura del Plan de Salud para dicho dependiente terminará el primer día del mes posterior a la fecha en que no se cumplan alguno de estos requisitos.

Nombre del dependiente | Número de Expediente Médico del dependiente

Fecha de nacimiento | Número de Seguro Social del dependiente

Nombre de la escuela

Dirección de la escuela

Ciudad, estado, código postal

Número de identificación del estudiante | Número de unidades que estudia

Nombre del suscriptor | Número de identificación del comprador

Número de cuenta de la familia

X
Firma del suscriptor

Número de Seguro Social | Fecha

Empleado: Devuelva el formulario contestado a su empleador; o si recibió el formulario con una carta, por favor devuelva el formulario en el sobre comercial de devolución que se adjunta.

Empleador: Si Kaiser Permanente otorga un certificado a sus estudiantes, envíe este formulario a la dirección donde manda sus documentos de membresía.

KAISER PERMANENTE.

SAMPLE FORMS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

Subscriber Termination and Transfer Form

KAISER PERMANENTE®

Subscriber Termination and Transfer Form

Use this form for billed purchasers to request subscriber/account terminations and/or subscriber/account transfers from one enrollment unit to another within the same purchaser ID and region. **Do not use this form for new subscriber enrollments and/or dependent additions or terminations.**

Purchaser information

Today's date _____

Purchaser name _____

Purchaser/enrollment unit number _____ – _____

Billing contact name *(please print)* _____ Telephone number ( ) _____

E-mail address *(optional)* _____ Fax number ( ) _____

❒ Check here if billing contact information is new

Termination or transfer requests *(refer to the processing rules on page 2)*

Subscriber name	Subscriber medical record number	Subscriber Social Security number	Termination or transfer effective date *(see page 2)*	Termination or transfer reason code *(select from table below)*	Indicate new enrollment unit *(required for transfers only)*

Termination reason codes

1–Employment terminated	**3**–Leave of absence	**5**–Military duty	**7**–Enrolled in error	**9**–Subscriber requested
2–Subscriber retired	**4**–Layoff	**6**–Subscriber deceased	**8**–Loss of disabled status	

Transfer reason codes
(refer to page 2 for additional information)

10–Open enrollment plan changes	**13–Employment status change:** • Start or termination of employment of the employee's spouse • Start of, or return from, leave of absence • Change from salaried to hourly or vice versa • Change from part-time to full-time or vice versa • Employee retirement • Strike or lockout • Significant change in health coverage of the employee or spouse attributable to the spouse's employment	**14–Marital status change:**† • Marriage • Death of employee's spouse • Divorce or annulment • Legal separation	**15–Dependent status change:**† • Birth • Adoption or placement for adoption • Death of dependent child • Newly eligible dependents due to employer change in eligibility rules • Dependent loss of eligibility due to age, student status, or marriage
11–Change in geographic service area*			
12–Loss of coverage: • Spouse or dependent loss of coverage • Reaching lifetime maximum			

*For transfer reason code 11, submit a completed Group Enrollment/Change Form signed by the subscriber providing the new address.
†For transfer reason codes 14 or 15, submit a completed Group Enrollment/Change Form signed by the subscriber if adding or removing a dependent(s) from the subscriber's account. Refer to page 2 for additional information.

SAMPLE FORMS (FOR MTL HMO/ DHMO AND KPIC ACCOUNTS)

COBRA Enrollment Form

KAISER PERMANENTE®

COBRA Enrollment Form

This enrollment form must not be submitted to Kaiser Permanente. Ask your former employer where you should send this form. Complete all fields or you may have a delay in your enrollment. Please print or type in black or dark blue ink only.

TO BE COMPLETED BY EMPLOYER

Purchaser/Enrollment Unit Number	Employer	Employer Signature/Date

Enrollment Information

Please check the reason for enrollment and complete the maximum months of coverage. ***NOTE:*** *If requesting a transfer of an existing COBRA account from another carrier to Kaiser Permanente, you must indicate the qualifying event for the initial COBRA enrollment.*

Reason for COBRA Enrollment

- ❑ Date of termination of employment: MO _____ DAY _____ YEAR _____
- ❑ Date of reduction of work hours: MO _____ DAY _____ YEAR _____
- ❑ Loss of spousal or dependent status: Effective Date of Loss: MO _____ DAY _____ YEAR _____
  Reason for loss: ○ Marriage ○ Divorce or legal separation ○ Death of subscriber ○ Reached maximum age ____
  ○ Subscriber's Medicare entitlement ○ Other _____
- ❑ Transfer of existing COBRA account from another carrier to Kaiser Permanente
  Carrier's Name & Telephone Number _____
  Policy Number _____ Policy Term Date _____
  Original initial COBRA enrollment reason _____
  Original initial COBRA coverage start date _____

Maximum months of coverage _____

Additional Enrollment Information

- ❑ Qualified beneficiary on the account is disabled pursuant to US Social Security Act
- ❑ Applying for Health Care Tax Credit (TAA/HCTC) through the Federal Government. (Please attach a copy of your potential eligibility letter.)

TO BE COMPLETED BY EMPLOYEE

Please list all members to be enrolled in the account. With the exception of annual Open Enrollments or Special Enrollments due to HIPAA, only a spouse and dependent children included in the prior group coverage may be enrolled as part of your COBRA account. (Attach additional sheet, if needed.)

Subscriber Information

Name: *(Last/First/MI)*	Social Security number	Date of birth	Gender *(circle one)* **M F**

Address: *(Street/City/State/ZIP)*

Day phone number	Alternate phone number	Email address (for enrollment purpose only)

During this employment was Kaiser Permanente your group coverage? ❑ Yes ❑ No

Family Information

	Name: *(Last/First/MI)*	Role	Social Security number	Date of birth	Gender *(circle one)*
Spouse or domestic partner (if eligible)		○ Spouse ○ Domestic partner			**M F**
Dependent		○ Child ○ Student			**M F**
Dependent		○ Child ○ Student			**M F**
Dependent		○ Child ○ Student			**M F**

I, on behalf of myself and my family members listed on this Form, if any, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations and other terms and conditions of the Group health plan documents, including the Evidence of Coverage. I have reviewed the statements on this form and they are true and correct. The Health Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in this Form.

Note: Use of binding arbitration does not apply to Kaiser Permanente Insurance Company or Out-of-Network service disputes

Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

Signature _____ Date _____

SAMPLE FORMS (FOR KPIC ACCOUNTS)

KPIC's Enrollment/Account Change Form

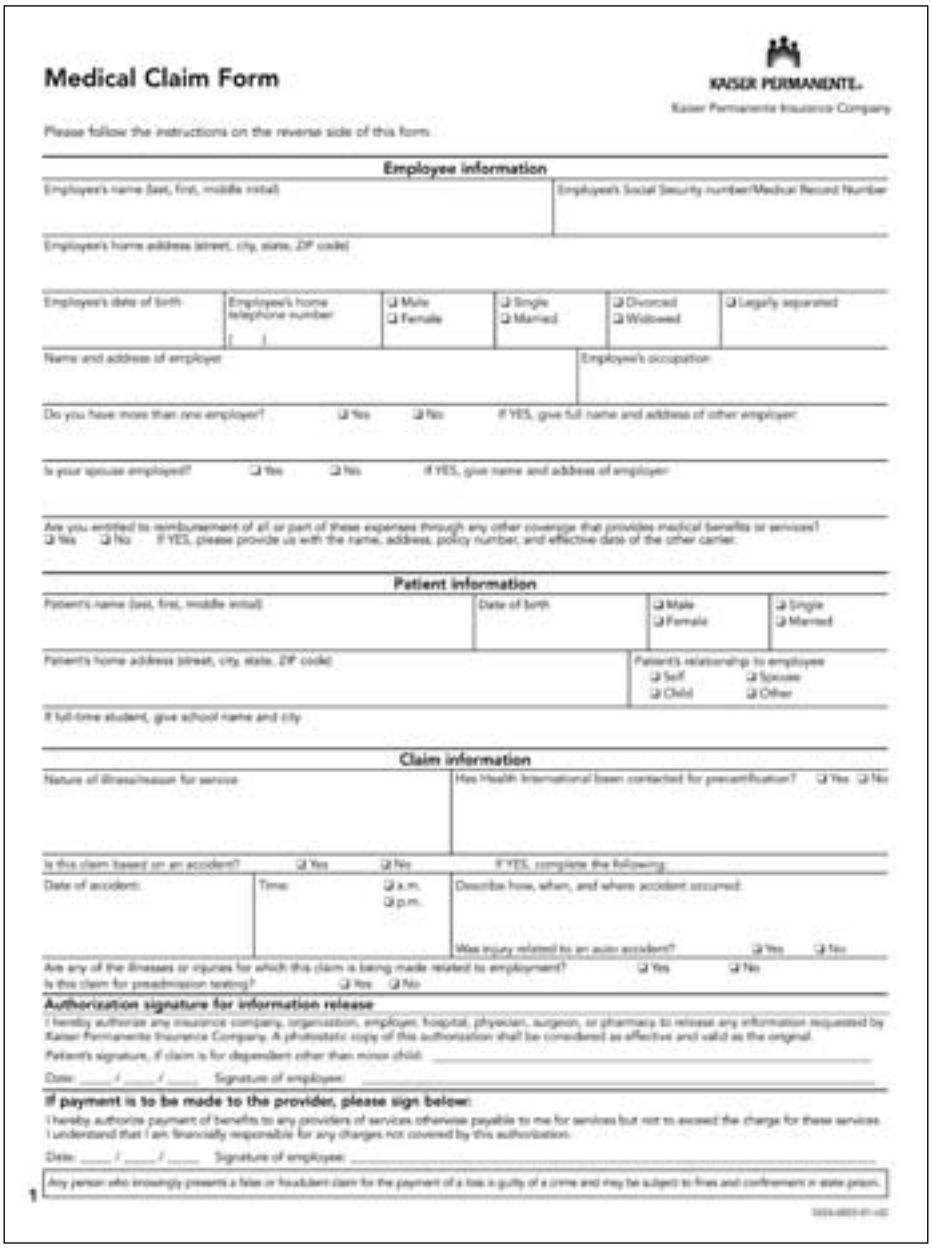
Enrollment/Change Form

Enrollment/Change Form

TABLE OF REASONS FOR CHANGE

SAMPLE FORMS (FOR KPIC ACCOUNTS)

KPIC Medical Claim Form



Medical Claim Form

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Please follow the instructions on the reverse side of this form.

Employee information

Employee's name (last, first, middle initial) | Employee's Social Security number/Medical Record Number

Employee's home address (street, city, state, ZIP code)

Employee's date of birth | Employee's home telephone number ( ) | ❑ Male ❑ Female | ❑ Single ❑ Married | ❑ Divorced ❑ Widowed | ❑ Legally separated

Name and address of employer | Employee's occupation

Do you have more than one employer? ❑ Yes ❑ No If YES, give full name and address of other employer:

Is your spouse employed? ❑ Yes ❑ No If YES, give name and address of employer:

Are you entitled to reimbursement of all or part of these expenses through any other coverage that provides medical benefits or services?
❑ Yes ❑ No If YES, please provide us with the name, address, policy number, and effective date of the other carrier.

Patient information

Patient's name (last, first, middle initial) | Date of birth | ❑ Male ❑ Female | ❑ Single ❑ Married

Patient's home address (street, city, state, ZIP code) | Patient's relationship to employee ❑ Self ❑ Spouse ❑ Child ❑ Other

If full-time student, give school name and city:

Claim information

Nature of illness/reason for service | Has Health International been contacted for precertification? ❑ Yes ❑ No

Is this claim based on an accident? ❑ Yes ❑ No If YES, complete the following:

Date of accident: | Time: ❑ a.m. ❑ p.m. | Describe how, when, and where accident occurred:

Was injury related to an auto accident? ❑ Yes ❑ No

Are any of the illnesses or injuries for which this claim is being made related to employment? ❑ Yes ❑ No

Is this claim for preadmission testing? ❑ Yes ❑ No

Authorization signature for information release

I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release any information requested by Kaiser Permanente Insurance Company. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient's signature, if claim is for dependent other than minor child: _____

Date: ____ / ____ / ____ Signature of employee: _____

If payment is to be made to the provider, please sign below:

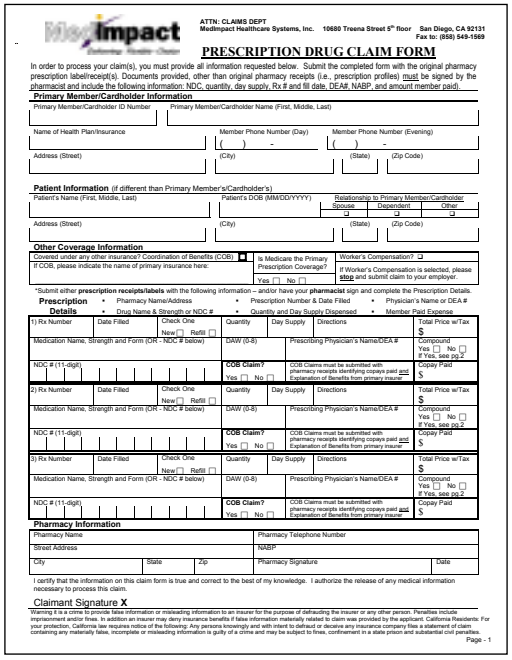
I hereby authorize payment of benefits to any providers of services otherwise payable to me for services but not to exceed the charge for these services. I understand that I am financially responsible for any charges not covered by this authorization.

Date: ____ / ____ / ____ Signature of employee: _____

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SAMPLE FORMS (FOR KPIC ACCOUNTS)

Direct Member Reimbursement Prescription Claim Form



MedImpact

ATTN: CLAIMS DEPT
MedImpact Healthcare Systems, Inc. 10680 Treena Street 5th floor San Diego, CA 92131
Fax to: (858) 549-1569

PRESCRIPTION DRUG CLAIM FORM

In order to process your claim(s), you must provide all information requested below. Submit the completed form with the original pharmacy prescription label/receipt(s). Documents provided, other than original pharmacy receipts (i.e., prescription profiles) must be signed by the pharmacist and include the following information: NDC, quantity, day supply, Rx # and fill date, DEA#, NABP, and amount member paid).

Primary Member/Cardholder Information

Primary Member/Cardholder ID Number | Primary Member/Cardholder Name (First, Middle, Last)

Name of Health Plan/Insurance | Member Phone Number (Day) ( ) - | Member Phone Number (Evening) ( ) -

Address (Street) | (City) | (State) | (Zip Code)

Patient Information (if different than Primary Member's/Cardholder's)

Patient's Name (First, Middle, Last) | Patient's DOB (MM/DD/YYYY) | Relationship to Primary Member/Cardholder: Spouse ❑ Dependent ❑ Other ❑

Address (Street) | (City) | (State) | (Zip Code)

Other Coverage Information

Covered under any other insurance? Coordination of Benefits (COB) ❑ | Is Medicare the Primary Prescription Coverage? Yes ☐ No ☐ | Worker's Compensation? ❑

If COB, please indicate the name of primary insurance here:

If Worker's Compensation is selected, please stop and submit claim to your employer.

*Submit either **prescription receipts/labels** with the following information – and/or have your **pharmacist** sign and complete the Prescription Details.

Prescription Details • Pharmacy Name/Address • Prescription Number & Date Filled • Physician's Name or DEA # • Drug Name & Strength or NDC # • Quantity and Day Supply Dispensed • Member Paid Expense

1) Rx Number	Date Filled	Check One: New ☐ Refill ☐	Quantity	Day Supply	Directions	Total Price w/Tax $
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg 2
NDC # (11-digit)			COB Claim? Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $
2) Rx Number	Date Filled	Check One: New ☐ Refill ☐	Quantity	Day Supply	Directions	Total Price w/Tax $
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg 2
NDC # (11-digit)			COB Claim? Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $
3) Rx Number	Date Filled	Check One: New ☐ Refill ☐	Quantity	Day Supply	Directions	Total Price w/Tax $
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg 2
NDC # (11-digit)			COB Claim? Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $

Pharmacy Information

Pharmacy Name | Pharmacy Telephone Number

Street Address | NABP

City | State | Zip | Pharmacy Signature | Date

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Claimant Signature X

Warning it is a crime to provide false information or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any persons knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

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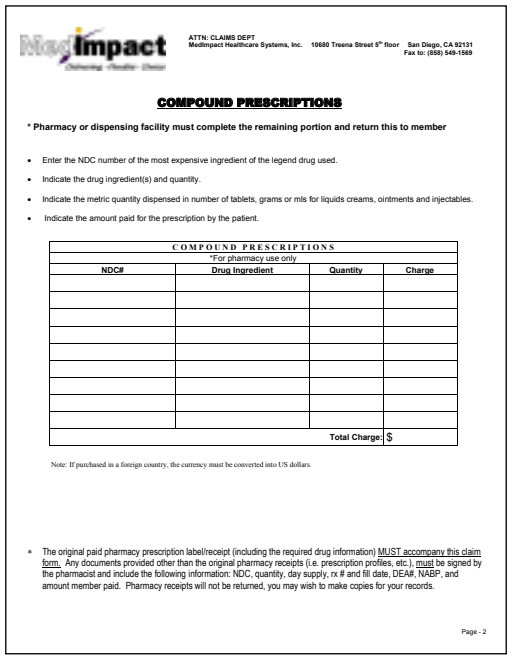

MedImpact

ATTN: CLAIMS DEPT
MedImpact Healthcare Systems, Inc. 10680 Treena Street 5th floor San Diego, CA 92131
Fax to: (858) 549-1569

COMPOUND PRESCRIPTIONS

*** Pharmacy or dispensing facility must complete the remaining portion and return this to member**

- Enter the NDC number of the most expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the metric quantity dispensed in number of tablets, grams or mls for liquids creams, ointments and injectables.
- Indicate the amount paid for the prescription by the patient.

COMPOUND PRESCRIPTIONS *For pharmacy use only			
NDC#	Drug Ingredient	Quantity	Charge
		Total Charge:	$

Note: If purchased in a foreign country, the currency must be converted into US dollars.

* The original paid pharmacy prescription label/receipt (including the required drug information) MUST accompany this claim form. Any documents provided other than the original pharmacy receipts (i.e. prescription profiles, etc.), must be signed by the pharmacist and include the following information: NDC, quantity, day supply, rx # and fill date, DEA#, NABP, and amount member paid. Pharmacy receipts will not be returned, you may wish to make copies for your records.

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How to file your claim:

1. Answer all questions and sign the "Authorization signature for information release" on the reverse side of this form.
2. Attach itemized bills. **Important:** Each bill must show (a) name of patient, (b) date each expense was incurred, and (c) nature of illness or injury.
3. Forward completed claim form and bills to:

   Kaiser Permanente Insurance Company
   P.O. Box 261155
   Plano, TX 75026

Account

A subscriber and all his or her eligible enrolled family dependents.

Account Administration Representative (AAR)

CSC Account Administration Representative (AAR) manages the administration, billing, and integrity of accurate membership information to ensure that members receive uninterrupted medical services while simultaneously safeguarding Kaiser Permanente's financial book of business.

Account manager

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

Account number

The subscriber's medical record number. The subscriber "governs" the account, and certain transactions applied to the subscriber account record will cause a change to all the member records within the account, such as a membership address change. A change to the subscriber's personal information (e.g., a birth date change) will only change the subscriber's record and not any member records within the account.

Activity period

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

Activity reason

Certain transactions, such as member enrollments or contract terminations, have a field to record the trigger, or reason, the activity took place.

Allocate

A payment, once received, is applied to a billing unit and then applied or allocated to a coverage period.

Apply

A received payment is applied to a billing unit.

Balance

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

Billing cycle

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

Billing date or billing schedule

The actual cutoff day for transactions used in dues-owed calculations for billed employers. It can be any calendar day of the month. The billing frequency and billing date together define the activity period for a specific billing unit.

Billing unit or enrollment unit

The customer-defined segment and associated facts (billing address, contact person, etc.) into which a health plan employer's or individual's transactions, such as membership activity, payment allocations, and adjustments, are grouped for billing purposes and reconciliation.

Broker

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

Cal-COBRA (California Continuation Benefits Replacement Act)

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

1. Qualified former employees, and their dependents, of employers of 2 to 19 eligible employees (including church groups).
2. Enrollees who have exhausted continuation coverage under federal COBRA, if the enrollee is entitled to less than 36 months of federal COBRA (the total months of continuation coverage under both federal COBRA and Cal-COBRA will not exceed 36 months).

Centers for Medicare & Medicaid Services (CMS)

The federal agency that administers the Medicare program

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

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

Client Services Unit (CSU)

Previously known as the Purchaser Services Unit (PSU), the CSU is a team of customer service experts who can answer your questions about large groups—those with 51 or more members.

COBRA

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

Coinsurance

The percentage of covered services to be paid by the member; it is the difference between the percentage payable by the company and the maximum allowable charge. Members are also responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

Contract

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

Contract option

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

Contract version

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

Conversion

The process whereby members who lose eligibility from customer, COBRA, or association or group coverage are offered the opportunity to continue Health Plan membership as individuals in a direct payment plan, without being medically evaluated. Individual coverage begins at the time customer, COBRA, or association or group coverage ends, and is subject to payment of the appropriate monthly charges.

Coordination of benefits (COB)

A health plan and insurance provision that outlines the method for determining payment when a member is covered by more than one health plan or insurance policy. COB determines the primary and secondary payer and ensures that no person or entity is reimbursed for more than the total cost of the care or services provided.

Copayment

A form of cost sharing in which an insured individual pays a portion of the cost for covered services by paying a flat fee at the point of service, such as a $5 doctor's office visit fee.

Coverage

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

Coverage effective date

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

Customer/purchaser/employer

An individual, organization, regulatory organization, or association that signs or may sign (prospect) a contract with KFHP to provide health care benefits.

Deductible

The amount of covered charges a member must incur while insured under the group policy, before any benefits will be payable during that calendar year.

Dependent

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

Disabled dependent—HMO users

A subscriber's or spouse's dependents who exceed the age limit for dependents are eligible for coverage if all of the following requirements are met: The dependent is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition that occurred prior to reaching the age limit for dependents, and receives 50 percent or more of their support and maintenance from you or your spouse. The subscriber must give Health Plan proof of this dependent's incapacity and dependency within 60 days after we request it.

Disabled dependent—KPIC users

An overage dependent child who is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition that occurred prior to reaching the limiting age and who is 50 percent or more dependent upon the insured for support and maintenance may continue coverage as a disabled dependent subject to the eligibility certification requirements. Insured must submit proof of such incapacity and dependency to Kaiser Permanente Insurance Company (KPIC) within 60 days of insured's receipt of KPIC's notice of the child's attainment of the limiting age and subsequently as may be required, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Disclosure Form

A form provided to potential members that sets forth the principal benefits, exclusions, and other important information about our Plan. Kaiser Permanente is required to provide potential members and enrolled members with information about our Plan. Prior to enrollment, Kaiser Permanente must provide the individual with a Disclosure Form setting forth the principal benefits, exclusions, and other important information.

Discrepancy

The difference between the amount due from an employer and the amount paid. An overage is payment of an amount over the amount due. A shortage is a payment of an amount less than the amount due.

Dues

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

Effective date

The date that services provided in the contract begin.

Eligibility requirements

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

Eligibility rules

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

Employer/purchaser/customer

An individual, organization, regulatory organization, or association that signs or may sign (prospect) a contract with KFHP to provide health care benefits.

End-stage renal disease (ESRD)

The stage of kidney impairment that is almost always irreversible and permanent, requiring a regular course of dialysis or kidney transplantation to maintain life. It is generally defined as 5 percent or less of normal kidney function remaining.

Enrollment reason

The reason for which a subscriber and dependents are enrolled. This may be done either by the individual signing up, by conditions of employment, or by another qualifying event.

Enrollment unit or billing unit

The customer-defined segment and associated facts (e.g., billing address, contact person) into which a health plan employer's or individual's transactions such as membership activity, payment allocations, and adjustments are grouped for billing purposes and reconciliation.

Estimated payment

A payment option under the Alternate Payment Plan. The estimated payment is an option to pay an estimated payment equal to 95 percent of the customer's prior monthly dues by the first day of the coverage month. By the end of the coverage month, the group must pay the balance of 5 percent, adjusted for membership additions and terminations.

Evidence of Coverage (EOC)

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

Family composition

The structure of the members within an account or unit. The family account can be composed of a subscriber, with or without one spouse, and with or without any number of dependents. In most cases, the number of family members affects the rate structure of the account.

Group Agreement

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

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

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

Health Plan

Kaiser Foundation Health Plan, Inc., a California nonprofit corporation.

ID card

Membership identification card that shows the member's medical record number used to identify medical records and membership information.

Indemnity

Traditional claims-based insurance plan, involving coinsurance terms and deductibles. Typically, there is an 80/20 percent split between the insurance company and the insured.

Kaiser Permanente Insurance Company (KPIC)

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

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

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

Loading

Any amount added to or subtracted from base rates to cover expenses and additional expected or unexpected variations in the cost of administering a contract.

MedImpact

A pharmacy benefits management company. As of January 1, 2003, MedImpact has provided Kaiser Permanente contracted pharmacies access to their online claims system to adjudicate claims for our POS, PPO, and Out-of-Area expansion members.

Member

Individual who is eligible to receive medical services and benefits, is enrolled under the *Evidence of Coverage*, and for whom we have received applicable dues.

Membership

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

Nonparticipating pharmacy

Any pharmacy that is not contracted through MedImpact.

Nonparticipating provider

Any licensed provider that is not contracted with PHCS Network or Health Plan to provide services to Kaiser Permanente members.

NSF

Nonsufficient funds. The way in which checks are designated when they are returned from the bank for nonsufficient funds.

Online account services

Kaiser Permanente's online service, which allows employers to maintain membership, pay dues, and view eligibility and billing information. To access online account services, go to **kp.org/ouremployers**.

Open enrollment

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

Out-of-Area

Out-of-Area Indemnity plan.

Overage dependent

A dependent who has reached the maximum age limit for dependent eligibility—usually, but not limited to, age 19. Some employers allow overage dependents the option to convert to Individual Plan account membership.

Participating pharmacy

Any pharmacy that is part of the KPIC-contracted MedImpact network of pharmacies.

Participating provider

Any provider that is part of the KPIC-contracted PHCS Network of providers.

Payment due date

The date by which payment is expected. In the case of a direct-reporting employer, a paid listing is due as well. Based on the billing schedule selected or determined during billing unit setup, the system will calculate the due date to be 30 days from the billing date.

Perot Systems, Inc.

The third-party administrator who processes and adjudicates claims on KPIC's behalf.

PHCS Network

Private Healthcare Systems Network. The national physician network that Kaiser Permanente Insurance Company (KPIC) has chosen to replace CCN (Community Care Network) for the POS and PPO plans as of July 1, 2006.

Plan

Kaiser Permanente Health Plan.

Policyholder

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

POS

Point-of-Service plan.

PPO

Preferred Provider Organization plan.

Precertification

The required assessment of the necessity, efficiency, and/or appropriateness of specified health services or treatment made by the Medical Review Program upon the request of the member or the member's attending physician prior to the commencement of any service or treatment.

Premium

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

Purchaser/customer/employer

An individual, employer group, organization, regulatory organization, or association that signs or may sign (prospect) a contract with KFHP to provide health care benefits.

Qualifying event

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

Rate change

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

Receivables

Estimated amounts of money earned but not received by the end of a specific month.

Reconciliation

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

Remittance advice

A remittance advice/payment coupon should be sent with a payment and contains information relating to the payment, such as billing unit, billed amount, paid amount, and coverage period.

Retroactivity

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

Service area

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

SHPS

KPIC has contracted with SHPS, a third-party provider, to provide precertification, utilization management, and case management services. Members using out-of-network benefits such as a hospital stay, surgery, skilled nursing facility stay, or acute rehabilitation services, on any of the KPIC indemnity plans, are assured that SHPS will be there to ensure the services they receive are both medically appropriate and cost-effective.

Student

A dependent who has reached the age limit for a child specified by the employer's contract. He or she may be eligible to remain on his or her parent's group coverage if the employer allows for student coverage.

Student certification

Documentation supporting an overage dependent's enrollment as a student.

Subscriber

1. A person on his or her own behalf and not by virtue of dependency status who, as either an employee or an employer or as a subscriber, is accepted for enrollment and continuing coverage, who meets all the acceptable eligibility requirements, who is enrolled, and for whom payment or a guarantee of payment has been received by the Health Plan.

2. A member who is eligible for membership on his or her own behalf and not by virtue of dependent status, and who meets the eligibility requirements as a subscriber.

TEFRA

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) extended Medicare payment limits to ancillary services, added Medicare coverage of hospice care, and allowed Medicare to sign risk contracts with HMOs and other competitive medical plans. It also limited Medicare's liability for people over age 65 who are still working, by making their employer's insurance primary.

Termination

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

Workers' compensation

An employee benefit established by the California legislature. Compensation is provided for disability, death, or medical care resulting from accidental injury or disease that is related to employment, regardless of who is at fault. Employers are required to provide medical treatment.

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