CALIFORNIA

Employer

Small Group Administrative Handbook

A guide to managing your account

January 2024

Learn more at **account.kp.org**

KAISER PERMANENTE®

Make the most of your smart decision

You've made an important investment in your business by offering your employees the convenience and care of Kaiser Permanente's better model of health coverage. We want to ensure you and your employees get the most out of everything we offer and get an even better return on your investment.

This handbook provides important information on how to administer your Kaiser Permanente plan(s) and access online services to manage your small business health coverage with a wide range of time-saving self-service features designed to help make health plan coverage decisions easier and more convenient.

Thank you for choosing Kaiser Permanente!

Table of Contents

Call us at **800-790-4661** if you have any questions or need any help.

For benefits administrators	
account.kp.org • Manage employee enrollments, terminations and business contract renewals • Update contact information • Submit electronic signature forms • Access Summary of Benefits Coverages (SBCs) and *Evidence of Coverages* (EOCs) • View billing statements and pay online • Order ID cards	Web Support Team Monday to Friday, 8:30 a.m. to 5 p.m. PT • Online access • Password resets • Navigation assistance Phone: **800-790-4661, option 4** Include company name and Group ID number Email: **csc-sd-cas-web-support@kp.org**
Enrollment and Billing: Small Business Services • Benefit and eligibility requirements • Billing • Member enrollments/terminations • COBRA • Medicare/Medicaid • Initiate EDI/834 file feeds by email: **kp834@kp.org**	Monday to Friday, 8 a.m. to 5 p.m. PT Phone: **800-790-4661, option 1** Include company name and Group ID number Email forms to: **csc-sd-sba@kp.org**
Employer Literature Request: Client Services Unit • Bulk open enrollment packets and brochures • Copies of contracts, EOC interpretation • Request 5500 Schedule A • 1095-B forms by email: **mec@kp.org**	Monday to Friday, 8 a.m. to 5 p.m. PT Phone: **800-790-4661, option 2** Include company name and Group ID number Email: **csu.ca@kp.org** Fax: 1-800-369-8010
Account Management Support Team • Renewal and renewal date changes • Plan change requests • Rate and general benefit inquiries • Open enrollment requests • Training for account.kp.org self-service and benefit updates	Monday to Friday, 8 a.m. to 5 p.m. PT Closed noon to 1 p.m. Phone: **800-790-4661, option 3** Include company name and Group ID number Email: **amt@kp.org** Fax: 1-800-369-8010
Service and Care Delivery Inquiries: Employer Broker Services (EBS) support such as: • Service resolution for access to care, benefits, deductible accumulations, and claims • KPIC/Choice products, and Consumer Directed Health Care (CDHC) • Broker of Record changes	Monday to Friday, 8 a.m. to 5 p.m. PT Closed noon to 1 p.m. Phone: **877-762-8247** Include company name and Group ID number Email: **ca.kp.ebs@kp.org**

Where and How to Submit Payments and Forms	
Billing and Payments	Managing your account is easy on account.kp.org. View billing statements and pay online for immediate transactions to keep your account current. Access Billing Clarifications FAQs for important tips.
Forms	Most administrative tasks can be completed online on account.kp.org or by completing the following electronic signature forms: Employee transactions (Employer must provide the links to the employee for them to complete and request they retain a copy for their records.): • Employee Enrollment • Employee/Dependent Change • Subscriber Termination, Transfer, and Reinstatement Employer/Business transactions: • Employer Attestation for COBRA/Cal-COBRA & TEFRA Status • Plan Add/Change Request • Customer Name or Address Change Request • Contact Change Request- (for contract signer, billing contact, and/or Third-Party Administrator (TPA) changes) • Broker of Record Authorization • Primary Administrator Online Access Request If you require a form that is not listed above, visit Forms and Documents, to complete the fillable forms and email, fax, or mail to addresses noted on the forms.

For your employees	
Member Services Contact Center • Member level benefit and eligibility inquiries • Member demographic updates • Explanation of benefits • Facility locations and physician directories • Pay bills and estimate costs	Phone: **800-464-4000** 24 hours a day, 7 days a week (closed holidays). For TTY call **711.** Or log into **kp.org**
New Hire Preenrollment Support New employees can speak to a licensed specialist for help with making an informed decision and choosing the right plan.	Monday to Friday, 7 a.m. to 6 p.m. PT Phone: **855-925-2991** Learn more at **k-p.li/JoinKP**
Kaiser Permanente Continuation of Coverage	**continuecoverage.kaiserpermanente.org**
Kaiser Permanente Medicare Advantage	**kp.org/medicare**
Claims Claims for emergency care and out-of-area urgent care provided to our members by non–Kaiser Permanente providers.	Claims and Benefits Member Service Monday to Friday, 4 a.m. to 6 p.m. PT Phone: **800-390-3510** Claims can be submitted by active employees by clicking here or by following the instructions below: 1. Log onto **kp.org** 2. Go to the menu bar > Billing 3. Go to Understand your costs > Submit a claim 4. Click the Submit Medical Claim Online button Or mail Claim Form to: Claims Administration Department- Northern California P.O. Box 12923 Oakland, CA 94604-2923 Claims Administration Department- Southern California P.O. Box 7004 Downey, CA 90242-7004

Account.kp.org

Manage your group coverage online

Save time administering your group coverage by completing most major administrative transactions quickly on **account.kp.org**. These services are available for your convenience at all hours every day of the year to suit your schedule.

Access features through **account.kp.org**, where you can easily:

- Enroll, change, or terminate coverage for employees and family members.
- Make membership address changes.
- Order ID cards and download member rosters.
- Check the status of your online transactions, including enrollments.
- View monthly bills, make payments, and view transaction history.
- Set up billing reminders and convenient automatic payments.
- View, download, print, and email key documents like the Group Agreement and EOCs.
- Process group-administered federal COBRA enrollments.

Manage your contact information

- Keep your details up to date for faster and smoother transactions.
- Change email and physical addresses, or Employer Identification Numbers (EIN).
- Add, remove, or change contract signer and billing contact information.

Complete your renewal changes

- Complete plan changes, get quotes to compare your renewal options, and manage your enrollees during open enrollment in real time.
- Quickly compare plans, rates, and benefit options, and see your entire transaction history all in one place.
- Get Employee Enrollment Worksheets that show employer medical contributions, employee monthly costs, and high-level benefit details personalized for each employee.

View the tutorial to get started or call account.kp.org support at **800-893-2971**.

For an **account.kp.org** User Guide, click here.

Registering for an account

1. Go to **account.kp.org**
2. On the page with "Welcome, brokers & employers" click "**Register**"
3. Complete the registration fields to create a user ID and password. Once registration is complete, the homepage will appear stating: **"Success! You've created your account."** Click **"Sign in to your account"** to continue. Please note, at this point the account has been created but still requires the remaining steps to link your secure group information.
4. On your dashboard, click the link **"fill out this online account services application form,"** in the primary group administrator section, and complete the web form. An electronic signature form is also available here.
5. A confirmation number will be provided upon submission of the web form. The estimated processing time is 3 to 5 business days.
6. Once the request has been processed, an email notification will be sent to your designated user with additional sign-on instructions. You can then create additional user IDs for access to the site. You can vary user privileges according to their responsibilities. You'll find this function

under the **"Account Access"** drop-down menu within the web.

Note: If you have a designated broker of record, they and their support team will be granted access to your account on **account.kp.org**. They will be able to provide administrative support to manage and make transactions on your behalf. You as the primary group administrator have the authority to add or remove a broker's access at any time on **account.kp.org**. If you change to a new broker of record, they will be granted access to your group on **account.kp.org** within 30 days of the change.

Membership enrollment

Open enrollment

Open enrollment is an annual event that occurs the month before your renewal. During open enrollment, you must offer health coverage to anyone eligible, including those who previously declined coverage when they became eligible. Subscribers can also add dependents not previously enrolled.

If you offer multiple plan options, current subscribers can change from one plan to another.

Enrolling new employees

You can complete new enrollment under "Manage Members" on **account.kp.org** for immediate processing or by sending the employee this link to the Employee Enrollment electronic signature form for them to complete. Please ask the employee to retain a copy for their records.

Note: Submit the new enrollee enrollment on **account.kp.org** at least 2 to 3 weeks before the effective date to ensure adequate time to process and receive member ID cards.

New employees who were former Kaiser Permanente members will continue using their existing medical record number.

Subscribers and/or dependents can be added retroactively up to 2 months prior to the month the request is received.

Check your email or log in to **account.kp.org** to confirm enrollment. For assistance, contact Small Business Services at **800-790-4661, option 1.**

Enrolling eligible dependents

If you offer dependent coverage, you can complete the enrollment under "Manage Members" on **account.kp.org** or by sending the employee this link to the Employee Enrollment electronic signature form for them to complete during new employee enrollment or open enrollment (If requesting to enroll dependents outside of the new employee enrollment or open enrollment period, please see Special Enrollment Period section below). Please ask the employee to retain a copy for their records. Dependent children can remain on the group plan until age 26.

Disabled overage dependent children

Disabled dependents who meet the eligibility requirements can remain on the plan beyond age 26.

Contact the Member Service Contact Center at **800-464-4000** for assistance.

Declination of coverage documentation

Each eligible employee declining group health coverage must complete the Waiver of Coverage form and you must retain for your records.

Special Enrollment Period (SEP)

Employees and dependents may be eligible for SEP when certain qualifying life events occur, and they must be enrolled within 60 days of becoming eligible per the qualifying event. Proof of documentation or court ordered documents must be provided.

Coverage begins on the first day of the month following the date of the qualifying event.

- Marriage or addition of domestic partner
- Death of a spouse, domestic partner, or dependent
- New birth
- Adoption or placement for adoption
- Involuntary termination or loss of other coverage
- Relocation to new service area
- Return from a leave of absence (e.g., medical, military, workers compensation, etc.)
- Increased work hours to meet medical plan eligibility
- Qualified medical child support order (QMCSO)
- Court order

Under the SEP, the subscriber can elect to change to a different available midyear plan option to afford the enrollment.

To add a dependent during the SEP, you can make the change under "Manage Members" on **account.kp.org** for immediate processing or by sending the employee this link to the Employee/Dependent Change form. Please ask the employee to retain a copy for their records.

Copies of court documents are required for a qualified medical child support order. However, documentation is not required to be added as dependent for domestic partnership, newborn or newly adopted. Kaiser Permanente reserves the right to request documentation for review.

Enrolling rehired employees

If the rehire date is within one year of the original termination date, coverage for the rehire is effective on the first of the month following the date of rehire.

If the rehire date is more than one year after termination, the employee will be considered a new hire and must first satisfy the new-hire waiting period, as described in your Group Agreement. Submit the change under "Manage Members" on **account.kp.org** or have the employee complete the Employee Enrollment form. Instruct the employee to select the "Other" checkbox, indicate "new hire" and the requested effective date of coverage. Please ask the employee to retain a copy for their records.

Updating enrollment information

To update enrollment information — such as adding/deleting a dependent, changing plans, employee name change, or employee demographics — submit the changes under "Manage Members" on **account.kp.org** or by sending the employee the link to the Employee/Dependent Change form for them to complete. Please ask the employee to retain a copy for their records.

Membership termination

Terminating membership

All membership terminations will be effective in the month the request to terminate is received, unless the group requests that the termination be effective in a future month. Retroactive termination prior to the month we receive the request is not permitted. Employers must report a termination for anyone who becomes ineligible for coverage.

To terminate membership coverage, submit the changes under "Manage Member" on **account.kp.org** or by completing the Subscriber Termination, Transfer and Reinstatement electronic signature form. Please ask the employee to retain a copy for their records.

When an employee's coverage is terminated, the entire family account is terminated. Depending on the reason for termination, the employee and dependents may be eligible to continue their Kaiser Permanente through our:

- Individual and Families
- COBRA continuation coverage
- Cal-COBRA continuation coverage

For information on Kaiser Permanente for Individuals and Families click here or visit **kp.org**.

For additional information on COBRA, click here.

Terminating dependent and overage dependent coverage

Dependent coverage is offered up to age 26 and is extended through the end of their birthday month. Kaiser Permanente will notify the group of dependents soon turning 26 years old. They will no longer qualify for coverage through a parent and be terminated from group coverage. See your Group Agreement for additional details.

Divorce, legal separation, and termination of domestic partnership

If an employee divorces, legally separates, or terminates a domestic partnership, the spouse or domestic partner no longer qualifies for coverage. To terminate the dependent's coverage, submit the change under "Manage Members" on **account.kp.org** or have the employee complete the Employee/Dependent Change form. Please ask the employee to retain a copy for their records.

Voluntary termination by employee

If an employee chooses not to continue with Kaiser Permanente, you can update this information under "Manage Members" on **account.kp.org** or have the employee complete the Subscriber Termination, Transfer and Reinstatement electronic signature form.

Certificates of creditable coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that certificates of creditable coverage be issued to terminated Kaiser Permanente members. The certificates document health coverage during Kaiser Permanente membership and are the primary means individuals use to prove prior creditable coverage when seeking new group coverage or coverage in the individual market. Certificates are mailed to the member's home address shortly after the termination date.

Members with an active membership status are also entitled to receive a HIPAA certificate of creditable coverage within a reasonable time following submission of their request to Member Service Contact Center. For more information, call **800-464-4000.**

Assisting your employees

New hire preenrollment support

Licensed specialists are available to help new employees make an informed decision with choosing the right plan.

Our licensed specialists can answer questions about:

- Cost and coverage details
- Benefits of our integrated care and coverage model
- Access to specialty care and telehealth services
- Prescription drugs covered by different plans
- Wellness classes, podcasts, self-care resources, and more

Our specialists are available Monday through Friday, 7 a.m. to 6 p.m. PT at **855-925-2991.**

New member welcome for employees

Once enrollment is approved, your employees will receive their ID card near their effective date, followed by additional information to help

them get started with Kaiser Permanente. If your employee provides a textable phone number, they will also receive a confirmation text.

Employees can manage their healthcare

Encourage your employees to register on **kp.org** to manage their health care online and/or download the Kaiser Permanente app to their mobile device.

Our website and app are their connection to great health and great care. Once they create their account, they can securely access time-saving tools and resources to stay on top of their care — anytime, anywhere:

- Schedule in-person, phone, and video routine appointments.
- Refill most prescriptions.
- Email their doctor's office with nonurgent questions.
- View most test results.
- Pay bills and estimate costs.
- Print vaccination records for school or sports.
- Check plan benefits and view claims.
- Manage a family member's health care.

With our app, members can access their digital member ID card to use just like their physical ID card.

If employees need additional help getting started with Kaiser Permanente, they can click **"call us for new member onboarding support"** at the bottom of **kp.org/newmember** to locate the phone number for their area.

Employer obligations

While brokers provide valuable administrative support, as the employer and administrator of your Kaiser Permanente health benefits, you are solely accountable and required to provide your employees and their dependents with the following:

- Plan specific Summary of Benefits and Coverage
- Plan specific *Evidence of Coverage*
- Notification of enrollment
- Notification of leaves of absence
- Notification of member termination
- Administering COBRA coverage
- Indicating ERISA status

Kaiser Permanente recommends you consult your legal counsel, tax advisor, and financial experts for advice related to plan administration, ERISA, and the Affordable Care Act (ACA).

Summary of Benefits and Coverage (SBC)

Our Summary of Benefits and Coverage document meets the required format to summarize important information about each health plan option, so you can easily compare Kaiser Permanente benefits and coverage with those of other carriers. SBC documents for each of our plans are available at **account.kp.org/business/sbc-summary-benefits-coverage/small-business.**

The ACA requires the employer to provide SBC documents for new and midyear plan changes to employees and their dependents at least 60 days before the new plan's effective date. An attestation is required for health coverage changes.

Note: If you provide SBCs electronically, you must comply with the SBC regulations. For more information, visit **dol.gov/ebsa/healthreform** or contact the Client Services Unit at **800-790-4661, option 2.**

Scenarios and time frames for providing SBCs:

Event	Description	Time frame for providing SBCs
Renewal	During open enrollment (if employees and dependents must actively elect to maintain coverage or if they have the opportunity to change coverage). If the person is already enrolled in a plan, the law requires you to provide an SBC only for that plan.	No later than the date open enrollment materials are distributed. No later than 30 days before the first day of the new plan year, if renewal is automatic and we issue the Group Agreement (or otherwise renew) more than 30 days before the first day of the new plan year. No later than 7 business days after we issue the Group Agreement or receive written confirmation of the group's intent to renew (whichever is earlier), if renewal is automatic and we haven't issued the Group Agreement (or otherwise renewed) more than 30 days before the first day of the new plan year.
Newly eligible employee	When an employee is first eligible to enroll.	As part of any written application materials (or no later than the first day on which the employee is eligible, if there are no written application materials). By the first day of coverage, but only if there is any change in the SBC.
Special enrollments	When someone enrolls as a HIPAA special enrollee (due to a qualifying event).	Within 60 days after enrollment.
Request	If an eligible employee or dependent requests an SBC or summary information about the coverage.	No later than 7 business days after you receive the request.
Material modification (off-cycle plan change)	If there is a material modification that would change the SBC you most recently provided and that isn't in connection with a renewal or reissuance. A material modification is one that an average enrollee would consider to be an important change in coverage.	You must give notice to enrollees at least 60 days before the date the change becomes effective.
For additional information, including the Glossary of Medical and Health Coverage Terms and the SBC guide for fully insured employer plans, visit **kp.org/smallbusiness-sbc/ca**.		

Evidence of Coverage (EOC)

The EOC describes the plan specific health coverage, including benefits, cost sharing, limitations, exclusions, dispute resolution, and how to receive care. An EOC for each plan you offer is provided within your Group Agreement. It's your responsibility to provide your employees with a copy of their plan specific EOC, which are also available at **account.kp.org**

Eligibilty

Employer eligibility

Refer to the Small Business Guidelines for Employer Eligibility information.

Employee eligibility

- A full-time employee is a permanent employee actively engaged in the conduct of business on a full-time basis and must average 30 hours per week over the course of a month, be subject to withholdings on a W-2 form, and have met their group's waiting period, if applicable.
  - o A spouse or legal domestic partner of a sole proprietor owner or partner is not eligible without another valid W-2 employee.
- A full-time-equivalent employee is a permanent employee actively engaged in the conduct of the business working at least 20 hours but not more than 29 hours per a normal week, be subject to withholdings on a W-2 form, and have met their group's waiting period, if applicable.
- For proprietors, partners, or corporate officers to be eligible, they must draw wages, dividends, or other distributions from the business on a regular basis.

You are required to offer coverage to employees working an average of 30 hours a week and can choose to offer coverage to employees working at least 20 hours a week if eligibility requirements are met. If coverage is offered to one or more part-time employees, then coverage must be offered to all part-time employees working at least 20 or more hours per week. All subscribers must live or work inside the Service Area applicable to their coverage when they enroll.

Kaiser Permanente won't cover employees working fewer than 20 hours per week even if local laws require an employer to do so. Contracted or 1099 employees aren't eligible.

For proprietors, partners, or corporate officers to be eligible, they must draw wages, dividends, or other distributions from the business on a regular basis.

Minimum age

Kaiser Permanente requires all subscribers to be 18 years old as of the employer's contract effective date.

Minors can be subscribers when:

- documentation of emancipated minor status is provided.
- employer indicates unemancipated minors are eligible for coverage and a parent or guardian signs on the subscriber line to indicate they're the parent or guardian of the unemancipated individual.

Dependent eligibility

If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. See section 4980(H)(c)(2) of the Internal Revenue Code about Employer Shared Responsibility. If the employer allows enrollment of dependents, then dependent coverage is available to the following individuals:

- Legal spouse. Spouse includes same-sex spouses if all California Family Code requirements are met under Section 308(c) for a couple, or Sections 297 or 299.2 for a registered domestic partner.
- Spouse also includes domestic partners who meet the employer group's eligibility requirements for domestic partnerships.
  - Spouses or domestic partners who work for the same employer have the option to enroll as separate subscribers, or one can enroll as a dependent under the other's coverage. An employee can't be both a subscriber under one plan and a dependent under another plan offered by the same employer.
- An employee's or a spouse's children under age 26 (including adopted or placed for adoption children).
- Children under age 26 (not including foster children) for whom the employee or spouse is the court-appointed guardian (or was when the person reached age 18).
- Children under age 26 (not including foster children) whose parent is a dependent under the employee's family coverage (such as, eligible grandchildren of the subscriber), including adopted children or children placed with the employee's dependent for adoption. Additionally, they must:
  - be unmarried and don't have a domestic partner.
  - permanently live with and receive all their support and maintenance from the employee or spouse.
- Disabled dependents who meet dependent eligibility rules and satisfy incapacity and financial reliance requirements to be certified as disabled dependents under Kaiser Permanente policy and applicable California legal requirements. The age limit doesn't apply to disabled dependents.

Ineligibility

- Retirees and contractors (1099)
- Seasonal, temporary, and substitute employees
- Private households, domestic help, members of organizations (such as credit unions and fraternal order members), conservatorships, embassies, and family trusts.

The absence of a category in this list doesn't make it eligible by default.

Plan rating

How we determine your renewal rates

Rates for statewide employers are based on the headquarter location for both Northern California and Southern California contracts. When a group updates their address midyear, their rate changes will only occur at renewal. Proof of headquarter address may be required. We then adjust the plan rates according to rating factors applicable to the plan type — grandfathered (nonmetal) or metal. Final rates are based on actual group enrollment. Rates are guaranteed for 12 months and are valid only from the effective date stated in the group contract.

Metal plan rating, rating area and age band

Metal plan rates are calculated using 2 factors — rating area and member age. Claims or utilization experience are not used to determine member premium rates.

Rating area:

- Businesses located in California: rates are based on the business's physical address (ZIP+4 and county).

- Businesses located outside of California are assigned to rating area.
- A post office box or other purchased mailing address can't be used as the business's physical address location.

Age band

- Each family member has a separate rate based on their age as of the effective date of the group contract. This rate will be used for the full contract year and updated yearly at renewal.
- Age bands are 0–14, 15, 16, 17, 18, 19, 20, every age from 21 to 63, and 64+.
- A family will pay a premium per child up to 3 of the oldest children under age 21, each additional child after the third will be $0. **Note:** A premium will apply to every age from 21-26.
- All plans include child dental for members under 19 years old as of the group contract effective date. HMO plans apply the cost of child dental only to the 0–14, 15, 16, 17, and 18 age bands. PPO plans* include the cost of child dental coverage in the overall rate.

*Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan.

Final rates are based on actual group enrollment. Rates are guaranteed for 12 months and are valid only from the effective date stated in the group contract.

Grandfathered (nonmetal) plan rating

Grandfathered (nonmetal) plan rates are calculated using 3 factors — rating area, age band, and risk adjustment factor (RAF).

Rating area:

- If the business is located within our California service area: rates are based on the business's physical address (ZIP+4).
- If the business is located outside our service area or out-of-state: rates are based on the ZIP+4 where the highest number of covered employees reside.
- A post office box or other purchased address can't be used as the business's physical address location.

Age band

The subscriber's age as of the effective date of the group contract, plus the family size, is used to determine the rate. This rate is used for the full contract year and updated at renewal. Age bands are <30, 30–39, 40–49, 50–54, 55–59, 60–64, and 65+.

Family size categories:

- Employee only
- Employee and spouse
- Employee and child or children
- Employee, spouse, and child or children. If a family has more than one child under 26, the premium for each additional child after the first will be $0.

Risk adjustment factor (RAF):

- One RAF is applied to all grandfathered (nonmetal) plans and restricted to a 0.90 to 1.10 range. The RAF applied to a group at renewal won't increase by more than 10 percentage points from the RAF applied in the prior rating period.
- RAFs are calculated using a model that assigns risk scores to each enrolled member based on the member's age, gender, and the types of prescription drugs the member is taking.

Final rates are based on actual group enrollment. Rates are guaranteed for 12 months and are valid only from the effective date stated in the group contract.

Covered California for Small Business

If you qualify for the small business tax credit, you may want to offer your employees our coverage through Covered California. Covered California for Small Business (CCSB) is the state's health insurance marketplace (also called an exchange). Individuals and small businesses can compare and shop for health plans on its website. The small business tax credit is only available through participation in CCSB.

If you offer coverage through CCSB, your employees can easily compare and purchase any health plan from any participating provider in the metal level you choose. Because Kaiser Permanente participates at every metal level, you can continue offering your employees the high-quality, integrated care they already know and trust.

To learn more about CCSB, call **844-332-8384** or visit **CoveredCA.com**.

For information on enrollment provisions and other requirements, see below.

Annual renewal and plan changes

Your annual renewal process is easy. Approximately 60 days before your annual renewal date, you'll receive an email notification that your annual renewal is available to view online at **account.kp.org** along with a snapshot of your business's health plan(s) and enrollment based on information in our systems.

Account.kp.org is your 24/7 one-stop shop to access, view and manage your renewals and changes immediately

- Complete plan changes, get quotes to compare your renewal options, and manage your enrollees during open enrollment in real-time.
- Quickly compare plans, rates, and benefit options, and see your entire transaction history all in one place.
- Get Employee Enrollment Worksheets that show employer medical contributions, employee monthly costs, and high-level benefit details personalized for each employee.
- Access your full transaction history in one place.

If you're not making or reporting any plan changes, you don't have to do anything. Currently enrolled subscribers and their dependents don't have to resubmit enrollment applications or family account change forms.

You can make changes anytime within those 60 days before your effective date and these changes will take effect on your renewal date. You can choose to change or replace plans or add a plan with richer benefits, which generally has a higher premium. The number of plans that you're allowed to offer is based on group size. If you have a grandfathered (nonmetal) plan and move to a metal plan, you won't be able to go back to our grandfathered (nonmetal) coverage.

Change requests must be submitted on or before the last business day of the renewal effective month.

To make renewal changes on account.kp.org, go to "Make renewal plan changes" on your dashboard to submit changes for immediate processing. These renewal plan changes must be received by the 15th of the effective month by 11:59 p.m. Thereafter, renewal plan changes capabilities on **account.kp.org** will not be available after the 15th of the effective month.

To make renewal changes alternatively, your change requests must contain an email date, postmark, or fax date stamp to prove the

change request was submitted on time. A plan change request received:

- before or on the 15th by 5 p.m. (PT) of the month is effective the first of the renewal month.
- between the 16th and by 5 p.m. (PT) of the last business day of the renewal month is effective the first of the following month.

Changes will take effect on your renewal date. Deductible accumulation amounts may not be transferable.

If you have questions, contact your broker or email our Account Management Support Team at **amt@kp.org** and include your group name and ID. Click here to view renewal options and videos.

Midyear plan changes

Changes made outside of the renewal period is a midyear plan change as it results in a short contract of less than 12 months. Kaiser Permanente reserves the right to decline midyear plan changes requests such as:

- Midyear upgrades/downgrades/ replacements
- Downgrade due to financial reasons
- Midyear plan additions due to mergers/ acquisitions
- Midyear plan change requests must include an attestation for health coverage changes, submitted up to 120 days before your renewal effective date.
- Employers with accounts in good standing can use the electronic signature Plan Add/ Change Request form on or before the last business day of the renewal effective month. Forms submitted
  - before or on the 15th by 5 p.m. (PT) of the month are effective the first of the requested month, or a future effective month.
  - between the 16th and by 5 p.m. (PT) of the last business day of the requested month are effective the first of the following month.

Change requests must contain an email time and date stamp or date, postmark, or fax date stamp to prove the change was submitted on time

Deductible accumulation amounts may not be transferable. It may take up to 2 billing cycles for plan changes to be reflected on your bill. The ACA requires the group to provide Summary of Benefits and Coverage (SBC) documents to their employees and dependents at least 60 days before the new plan's effective date.

Multiple plan option (MPO)

The number of health plan groups can offer to their employees is based on the number of enrolled Kaiser Permanente subscribers:

- Groups with 1 to 5 enrolled subscribers may offer up to 4 HMO Kaiser Permanente plans, plus 1 PPO plan for a maximum of 5 plans.
- Groups with 6 or more enrolled subscribers may offer 1 or more HMO Kaiser Permanente plans, plus 2 PPO plan.

PPO plans may be offered in Multiple Plan Options. PPO plans are only available if Kaiser Permanente is the sole carrier. Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan.

If you have out-of-state employees, the maximum subscribership can't exceed 49% of the overall group enrollment. Example: A group of 10 subscribers can't have more than 4 out-of-state employees on a PPO plan.

Crossover guidelines for HMO and deductible plans

Deductible and out-of-pocket (OOP) maximums reset to $0 on a member's accumulation period start date. When groups make certain plan changes or benefit coverage in the middle of an accumulation period, it can raise questions whether the employees' deductible and out-of-pocket (OOP) maximum credits will cross over to the new plan or reset to $0 when the new plan takes effect.

The 2 most common reasons why a member's credits would reset to $0:

- A group is issued a new group number – a company consolidates or is acquired, or it transfers to or from CaliforniaChoice® or CCSB.
- A member moves to an individual plan from a group plan (or vice versa).

The common situations when a plan is changed in the middle of an accumulation period and whether deductible and out-of-pocket (OOP) maximum credits cross over to the new plan.

Administrative and other group changes

For immediate processing, access the Change Group Information link on **account.kp.org** landing page to make updates to the following administrative changes.

- About Business
  - Phone
  - Fax
  - Business Website
  - Employer Tax ID
- Renewal Delivery Preference
  - Mail
  - Online
- Employer Medical Contributions
  - Update medical contribution amount and/or contribution type

Scenarios	HMO to HMO	HMO to HDHP HMO (HSA-qualified) (or vice versa)	HDHP HMO (HSA-qualified) to HDHP HMO (HSA-qualified)
Employer/employee changes plan mid-accumulation period	Yes	Yes	Yes
Employee moves from one California region to another with same employer	Yes*	Yes	Yes*
Employee changes employer	No	No	No
Individual plan member enrolls in a group plan	No	No	No

- Contact Change Request
  - Add or update group contract signer, billing contacts or interested parties contact information.
  - Need to update the group mailing address, use the contact change request transaction and update the contract signer address.

Change of ownership

For change of ownership, contact your account manager, or Account Management Support Team at **800-790-4661, option 3,** or email **amt@kp.org**, to process specific required documents. Contract changes may be subject to Kaiser Permanente management approval.

Administrative Termination

Kaiser Permanente can terminate coverage under any of the following conditions if the employer:

- intentionally fails to enforce employee and dependent eligibility rules.
- fails to pay required premiums after the grace period has lapsed.
- fails to comply with underwriting requirements, including participation or contribution standards.
- commits an act of fraud or intentional misrepresentation of material fact.
- has no employees enrolled in a Kaiser Permanente small business plan.
- moves outside Kaiser Permanente's approved California service areas and has no employees enrolled in a Kaiser Permanente small business plan who live in the service area.

Kaiser Permanente can terminate an employee or dependent coverage if the individual directly or indirectly commits an act of fraud or intentional misrepresentation of material fact.

Voluntary termination

You can terminate your group coverage for any reason with 15 days advance notice as required by your Group Agreement. A voluntary termination can't override an administrative termination. To request termination, contact the Account Management Support Team at **800-790-4661, option 3.**

Contracts are terminated on the last day of the month.

Re-enrollment

For groups where Kaiser Permanente coverage is terminated for more than 60 days, the group may re-enroll as a new group provided the group still qualifies for small group coverage. A new coverage effective date, group number, and contract are issued.

If you terminated as part of the recertification process and wish to reinstate within 60 days, contact the Recertification Team at **877-490-4983.**

Coverage options following termination of coverage

If your group coverage is terminated, you and your employees may be eligible for individual plans. For more information, call our Member Service Contact Center at **800-464-4000**.

Extension of benefits for total disability

If your contract is terminated, medical coverage may continue for 12 months premium-free for a disabled employee or disabled dependent. Disability certification must first be reviewed and approved.

However, coverage will be terminated earlier if:

- The eligible employee or dependent is no longer disabled.
- The disability is covered by another group health plan.

Reinstatement

For groups where Kaiser Permanente coverage is terminated for less than 60 days, the group can request reinstatement of prior contract to avoid a gap in coverage, retain same group ID and renewal date and grandfather (nonmetal status). This request is conditional provided premiums due are paid in full and the group still qualifies for small group coverage.

All reinstatement requests must be approved by a manager, submitted on business letterhead, and emailed to Account Management Support Team at **amt@kp.org**.

Recertification

You will periodically be required to recertify that your group continues to meet small business eligibility and ownership requirements. As regulations, policies, and industry practices evolve, your group may be held to new standards. Kaiser Permanente will perform internal checks to confirm your business structure and physical business address prior to processing your group for renewal.

If your group doesn't pass recertification or is unresponsive to recertification requests, then your group is subject to termination. Contact your Kaiser Permanente representative for additional details.

Note: If you have a Medicare eligible employee who enrolls on our Senior Advantage plan, they are considered a non-covered subscriber but his or her dependents are eligible for enrollment on the group plan.

For more information about recertification, see the **"Employer Recertification"** section on the Forms & Documents page or call **877-490-4983**.

Federal and state regulations

The information in this section isn't intended as legal advice.

- Which COBRA plan applies to you?
- Federal COBRA is for groups with 20 or more employees.
- State (or Cal-COBRA) is for groups with 2 to 19 employees.

Comparison of COBRA and Cal-COBRA

How to see which former employees and dependents are currently enrolled in COBRA or Cal-COBRA

- If you're responsible for billing the member, you can see your currently enrolled COBRA members. View the billing unit on your account and select "Subscriber List" under "Member Functions."
- Request an updated report from us whenever you need to know which former employee(s) are enrolled through your Cal-COBRA account.
- This isn't an option in cases in which Kaiser Permanente is responsible for the billing because these accounts don't have a group billing unit and are billed directly to the member. To obtain a list of members enrolled in COBRA for whom Kaiser Permanente is responsible for the billing, contact our Small Business Services.

For further information on COBRA, call our Small Business Services, California Service Center at **800-790-4661, option 1.**

Comparison of COBRA and Cal-COBRA

	COBRA	Cal-COBRA
Benefits same as the group plan	Yes	Yes
Rates	The original group premiums, plus applicable administrative fee	The original group premiums, plus applicable administrative fee
Employee changes employer	For groups of 20 or more employees: all family members who were covered under the original group plan coverage	For groups of 19 or fewer employees: all family members who were covered under the original group plan coverage; also for subscribers who exhaust their COBRA coverage
Individual plan member enrolls in a group plan	The group administrator must call our Small Business Services, California Service Center at **800-790-4661, option 1**	The employee who's terminating must call the Member Service Contact Center at **800-464-4000**

Federal COBRA

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

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

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

Under the Employee Retirement Income Security Act (ERISA), the employer's Employee Welfare Benefit Plan has the fiduciary responsibility for all aspects of COBRA administration.

The plan administrator (as defined by ERISA) is either the employer or a third-party administrator appointed by the employer. Kaiser Permanente performs only clerical COBRA functions for employer groups. It hasn't and doesn't accept fiduciary responsibility as a COBRA administrator for any employer group.

Kaiser Permanente is, however, a plan fiduciary (as defined by ERISA solely) for determining the scope and extent of health coverage for those ERISA plan beneficiaries enrolled through the group as our members, including those participating through COBRA.

If your employees call Kaiser Permanente for federal COBRA enrollment information, they'll be told to contact their employer for assistance.

State COBRA

Cal-COBRA provides for the continuation of coverage for employees and eligible dependents for groups that employed less than 20 employees at least 50% of the working days in the previous calendar year. This law also applies to an eligible employer who wasn't in business during any part of the preceding calendar year if the employer employed 2 to 19 employees for at least 50% of the working days in the preceding calendar quarter.

Employers with a single employee aren't eligible for Cal-COBRA.

Kaiser Permanente provides administration for Cal-COBRA groups and is permitted to charge Cal-COBRA subscribers an administrative fee.

An employee and/or eligible dependents are eligible for up to 36 months of continuation of coverage under Cal-COBRA if coverage was terminated due to any of the following qualifying events:

- Death of the plan subscriber, for continuation of dependent coverage.
- Employee's termination of employment or reduction in hours.
- Spouse's divorce or legal separation from the subscriber.
- Loss of dependent status of enrolled child.
- Subscriber becoming entitled to Medicare.
- Loss of eligibility status of enrolled family member.

Employers are required to notify Kaiser Permanente within 31 days of a qualifying event. Employees terminated for gross misconduct aren't eligible for Cal-COBRA.

Billing and payment

- Kaiser Permanente provides administration for Cal-COBRA groups and is permitted to charge Cal-COBRA subscribers an administrative fee.
- For Cal-COBRA, Kaiser Permanente bills and collects directly from the subscriber.

Monthly billing of your COBRA members

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

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 whom Kaiser Permanente does the billing and collecting. This report will be generated monthly and should be received by the end of each month. The report will provide the COBRA member's name, Social Security number, address, family role, and the start and expected end date for COBRA coverage.

You can easily see your active COBRA members for whom Kaiser Permanente does the billing and collecting. It also includes those who have failed to make timely payments and those who are being terminated for nonpayment or for reaching the maximum period of COBRA coverage. If there is no COBRA activity for a reporting period, you won't receive a report.

How to enroll COBRA members

When an employee or dependent chooses Kaiser Permanente COBRA coverage, he or she submits the completed Kaiser Permanente COBRA enrollment form directly to the group.

You'll then submit the enrollment form and report any terminations the same way you usually report membership changes. We won't accept any COBRA enrollment forms directly from your employees.

Kaiser Permanente will accept enrollment only for the minimum time frames as specified in COBRA. Members who intend to elect and pay for COBRA coverage can use Kaiser Permanente services in between their termination from health coverage and their enrollment into COBRA. You should make them aware of the following:

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

Employee notification

It's 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 can 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).

ERISA status

As part of Kaiser Permanente's efforts to answer federal and state regulatory inquiries regarding member's claims and appeals related to the requirements, a group's Employee Retirement Income Security Act (ERISA) status must be verified. To ensure compliance, employer groups are asked to indicate their ERISA status initially on the Employer Application and then annually with the renewal notice to update Kaiser Permanente if the reported status is no longer valid.

The Employee Benefits Security Administration website (dol.gov/ebsa) has information about how to comply with ERISA requirements. Consult with a financial or legal advisor to fully understand your group health plan's ERISA status.

Federal TEFRA

- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) is a federal law that established Medicare Secondary Payer (MSP) rules. When MSP applies, Medicare isn't responsible for paying primary for a member's covered health care services when the member is age 65 or older and covered by a group health plan. An employer's group health plan MSP status is determined based on a yes or no response to the following question:
- Did a company employ 20 or more full-time and/or part-time employees for each workday for 20 or more calendar weeks in the current calendar year or preceding calendar year, making its group health plan subject to MSP?
  - If yes to the question, then the employer's group health plan is subject to MSP and will pay primary to Medicare.

  - If no to the question, then the employer's group health plan isn't subject to MSP and Medicare has primary payment responsibility.
- Regardless whether Medicare is primary or secondary, the following information applies to employees who are 65 years old, Medicare eligible, and enrolled in a group health plan (Medicare defines as "Working Aged"):

Kaiser Permanente doesn't require employees who are Working Aged to enroll in Medicare Parts A or B. Member copay and coinsurance will be the same as any other employee enrolled in that group's coverage. Penalties for enrolling late in Medicare Part B are waived while the individual is enrolled in qualifying group coverage.

- There's no balance billing per the normal terms in the *Evidence of Coverage* (EOC).
- If a group has 20 or more employees and an employee, who is Working Aged, enrolls in both Medicare Parts A and B, then the employee can enroll in the Kaiser Permanente Senior Advantage (KPSA) plan as an individual while still being covered under the group plan. This means Parts A and B are assigned to the KPSA plan, and through coordination of benefits with group coverage, the member has $0 deductible and $0 copay/coinsurance including prescription drugs. Covered benefits will be the same as employees on the group plan.
- For groups with 19 or fewer employees, the 65-year-old or older Medicare-eligible employee can enroll in the KPSA plan or remain on the group plan. They can't be enrolled in both.
- If an employee enrolls in both Medicare Parts A and B without enrolling in KPSA, then the member will typically pay $0 deductible and $0 copay/coinsurance through the coordination of benefits (COB) with Medicare and group coverage. However, prescription drugs are subject to applicable copay and cost shares including a separate drug deductible.
- If a former employee of a group becomes entitled to Medicare while being covered under COBRA continuation coverage (federal or state), then the member's eligibility for COBRA or Cal-COBRA will end. A former employee enrolled in or eligible for Medicare isn't eligible to enroll in Cal-COBRA.
- Medicare is also primary when either of the following criteria is met:
- The employee is covered by a group health plan, is under 65, is on Medicare due to a disability, and the employer has fewer than 100 employees. If the group has 100 or more employees, the group is the primary payor.
- The employee is covered by a group health plan, the beneficiary is on Medicare solely due to end stage renal disease (ESRD), and the 30-month coordination period has ended. The group is the primary payor during the first 30 months.

Small employer customer notification

Employers with 2 to 19 employees must notify Kaiser Permanente within 31 days of an employee's loss of group health coverage eligibility. If the loss of eligibility is due to gross misconduct, employers should notify Kaiser Permanente within 5 business days.

The employer/group sends a notification of Cal-COBRA to all group members terminating group health coverage.

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 Cal-COBRA, they should call the Member Service Contact Center at **800-464-4000.**

Binding arbitration

The state of California requires us to notify applicants at the point of enrollment of Kaiser Permanente's use of binding arbitration before they choose to enroll in a Kaiser Permanente plan. Binding arbitration is used to settle member disputes in a less formal proceeding than a civil trial in state or federal court, and it may lead to quicker dispute resolutions. This information is located above the employee application signature line to ensure the applicant understands and that they've read and agreed to our binding arbitration before providing their signature. Arbitration agreement is a condition of enrollment with Kaiser Permanente.

Compliance with state law and ensuring that your employees/applicants are properly informed depends on how you collect enrollments.

If you collect enrollments using a current Kaiser Permanente enrollment form: Your enrollment process is in compliance as long as you're using a current 2024 version of our form that includes a current version of our binding arbitration notice. If you're not sure how old your enrollment form is, contact our California Service Center, Small Business, at **800-731-4661, option 1**.

If you collect enrollments using your own form (universal form): This form must be certified by our arbitration team to include our most current arbitration notice. Submit your universal form to **MA-Arbitration@kp.org** for annual recertification. contact our Small Business Services, California Service Center at **800-731-4661, option 1.**

If you collect enrollments using an online enrollment website: We have developed a web service tool that makes it easier to display our binding arbitration notice and capture agreement to arbitration signatures at the point of enrollment. This tool, called the California Arbitration Management System (CAMS), is a web service that can be added to an enrollment website. If a group is using an online enrollment platform, the online enrollment platform must be approved by the arbitration team. If you use an online enrollment site, email **MA-Arbitration@kp.org**.

Regulations

California Health and Safety Code (HSC) Article 4, §1363.1

1363.1. 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:

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

- In any 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 group contracting with a health care service plan and immediately before the signature line provided for the individual enrolling in the health care service plan.

Additional Kaiser Permanente Benefit Offers:

Kaiser Permanente On-the-Job®

Keeping your employees healthy, happy, and on the job is our number one priority. That's why we offer the high-quality care of Kaiser Permanente On-the-Job. Our network of occupational health care centers can help your employees recover from workplace injuries or illnesses faster — and keep your costs down.

All your employees can take advantage of our Kaiser Permanente On-the-Job services, whether or not they're enrolled in a Kaiser Permanente plan.

How to become a part of Kaiser Permanente On-the-Job If your business isn't enrolled in Kaiser Permanente On-the-Job, you may be missing out on innovative tools and programs that can help your bottom line and protect your most valuable asset: your employees.

We offer programs that can help reduce absenteeism, keep your employees safe on the job, and help everyone at your business set and achieve individual health and fitness goals. It's a better way to help keep your whole staff healthy and safe.

For more information Visit **kp.org/employers/kaiseronthejob** or call us at **888-KOJ-WORK (888-565-9675).**

Kaiser Permanente Workforce Health

When you work so closely with your employees, you want to make sure they're healthy, happy, and taken care of. The great news is that helping your employees stay well can actually help your bottom line. Participation in workforce health programs can help reduce absenteeism and boost productivity.

We've developed online programs that are fast and convenient for small businesses to get up and running.

Let's get started

Encourage your employees to visit kp.org and click the "Health & wellness" tab. There they'll find tools and resources to help them thrive. Most are available at no cost, and some are available to both Kaiser Permanente members and nonmembers.

- The Total Health Assessment gives employees a personalized action plan that directs them to one or more healthy lifestyle programs to help them achieve their goals.
- Educational tools, including health and drug encyclopedias, calculators, and a symptom checker, give employees a clearer picture of their health.
- Healthy lifestyle programs coach employees on how to manage conditions such as back pain, depression, diabetes, and insomnia.
- Online health videos highlight a wealth of important health topics to keep employees informed and engaged on their wellness journey romon.
- The Total Health Radio online radio show and podcast offer employees health tips, advice, and guided-imagery audio programs.

Glossary

account.kp.org

Kaiser Permanente's web-based account management system, which allows employers to maintain membership, pay dues, and view eligibility and billing information.

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, 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.

agent of record

The individual or business authorized to represent a customer in the purchase, servicing, and maintenance of health benefit coverage with a designated insurer.

American Specialty Health Plans of California, Inc.

The administrator of the chiropractic/acupuncture coverage for our HMO plans.

balance

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

billing cycle

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

billing unit

The customer-defined segment and associated facts (billing address, contact person, etc.) into which an 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 a business, 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 of coverage for employees and eligible dependents for groups that employed less than 20 employees at least 50% of the working days in the previous calendar year. This law also applies to an eligible employer who wasn't in business during any part of the preceding calendar year if the employer employed 2 to 19 employees for at least 50% of the working days in the preceding calendar quarter.

Certificate of Insurance

The Certificate of Insurance (COI) describes benefit coverage funded through a Group Insurance Policy issued to your group by Kaiser Permanente Insurance Company. It becomes your Certificate of Insurance when you have met certain eligibility requirements.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, which requires 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.

continuation coverage

The extended coverage provided under the group benefit plan in which an eligible employee and/or eligible dependent is currently enrolled.

contract

An agreement that defines the non-period-specific provisions under which Kaiser Foundation Health Plan, Inc., (KFHP) commits to provide administrative services or health 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.

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 freeze

The period of time during which no contractual changes can be made.

conversion

The process by which members who lose their eligibility in a group or COBRA plan are offered the opportunity to continue their Kaiser Permanente membership in an individual direct-pay plan without being medically evaluated. Individual conversion coverage begins at the time the group or COBRA coverage ends and is subject to payment of the appropriate monthly charges.

coordination of benefits (COB)

A health plan and coverage provision that outlines the method for determining payment when a member is covered by more than one health plan or 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.

copay

A form of cost sharing in which a member 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

A business term used to describe the extent of the protection provided.

customer/employer

An individual, organization, regulatory organization, or association that signs a contract with Kaiser Permanente to provide health care benefits.

deductible

The amount of covered charges a member must incur while under the group policy, before any benefits will be payable during that 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 (KFHP plans)

A dependent who exceeds the age limit for dependents but is still 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% or more of his or her support and maintenance from the member disabled dependent (KPIC plans)

A disabled dependent child means your child of any age who is both:

- incapable of self- sustaining employment by reason of a physically or mentally disabling sickness, injury or condition; and
- 2) chiefly dependent upon you for support and maintenance.

downgrade

A move to a less-rich plan, generally a plan with a lower premium than a contracting employer's current plan.

dues

The premium; the amount of the charges per coverage period that a contracting employer or subscriber pays for health 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 the health plan. The eligibility rules govern the coverage effective and termination dates of their members.

Employer/customer

An individual, organization, regulatory organization, or association that signs a contract with Kaiser Permanente to provide health care benefits.

Enrollment unit or billing unit

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

event date

The date of a qualifying event that resulted either in the enrollment of an employee or in the addition or deletion of a dependent.

Examples of event dates include:

- Date of birth
- Date coverage was lost
- Date of hire
- Date of marriage
- Date of adoption
- Date of rehire

Evidence of Coverage (EOC)

The EOC documents that are included in your Group Agreement contain information about benefits, coverage, and other contract provisions that are pertinent to both you and your employees. After enrollment, you're responsible for providing employees with a copy of the EOC for the plan in which they're enrolled.

Explanation of Benefits (EOB)

A statement generated each time a member receives medical services that summarizes the services received, including the date and the provider's name. An EOB isn't a bill, but it can help the member keep track of their health care expenses. As a DHMO member, there may be some instances where the member might receive an EOB rather than a Summary of Accumulation; e.g., if the employer's plan

is self-funded, or if the member received emergency care outside of Kaiser Permanente group administrator. grandfathered plan (also known as nonmetal plan)

If your plan has covered at least one employee without lapse in coverage and continued unchanged since the ACA was signed into law on March 23, 2010, it's considered a grandfathered (nonmetal) plan.

Group Agreement/Contract

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

group ID

The unique ID by which we identify your business.

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.

Kaiser Permanente Insurance Company (KPIC)

A subsidiary of Kaiser Foundation Health Plan, Inc., that underwrites the PPO plan.

medical record number (MRN)

A unique identification number for a Kaiser Permanente member, typically printed on the member's identification card.

MedImpact

A pharmacy benefits management company has provided Kaiser Permanente–contracted pharmacies with access to their online claims system to adjudicate claims for our PPO, and out-of-area expansion members.

member

An individual who's eligible to receive health services and benefits, is enrolled under the *Evidence of Coverage* or Certificate of Insurance, and for whom we've received applicable dues.

member ID card

A membership identification card that shows the member's name, date of birth, and medical record number. Members need this card to access care at our medical facilities. A digital member ID card is also available on the KP app.

membership

The enrollment of a subscriber and/or dependents within an employer enrollment unit. This is a contractual agreement between an employer, a subscriber, and the health plan.

MultiPlan, Inc.

Participating providers in our PPO plan are part of the PHCS Network, a subsidiary of MultiPlan, Inc.

Note: KPIC has contracted with Private Healthcare Systems (PHCS) to provide access to hospitals and physicians with a commitment to keeping out of-pocket costs low through contracted rates. An online directory of Participating Providers can be found by visiting **www.multiplan.com/kaiser**.

open enrollment (OE)

The period when employees can choose among any employer offered health plans.

overage dependent

A dependent who has reached the maximum age limit for dependent eligibility, usually age 26. Some employers allow overage dependents the option to convert to an individual plan account membership.

participating provider physician

Participating providers in our PPO plan are part of the PHCS Network for KPIC[1] in California and other Kaiser Permanente states – Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia. The Cigna Healthcare℠ PPO Network[2] is available in all non-Kaiser Permanente states. Online directories of participating providers can be found by visiting **kp.org/kpic/ppo**.

1. KPIC has contracted with PHCS Network to give you access to providers with a commitment to keeping out-of-pocket costs low through contracted rates.

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

payment due date

The date by which payment is expected. The due date is usually 30 days from the billing date.

PHCS

Private Healthcare Systems

premium

The payment an employer or subscriber makes for health coverage and benefits for subscribers and dependents.

qualifying event

An event – such as marriage, birth, divorce, or loss of coverage – that allows an individual to make an election change or add or delete dependents on his or her health coverage.

rate

The amount an employer or subscriber is charged for health coverage and benefits for subscribers and dependents.

rate change

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

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

retroactivity

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

risk adjustment factor (RAF)

Small Group carriers use RAFs to determine a group's monthly premium. Group size and the number of COBRA enrollees may all affect a group's RAF.

service area

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

small business

As defined by AB 1672 modified by AB 1083; Section 1357.500 and SB 125, for plan years commencing on or after January 1, 2016; a small business is any person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50% of its working days during the preceding quarter, or preceding year, employed at least one, but not more than 100 full-time and full-time-equivalent employees, and wasn't formed primarily for purposes of buying health benefits coverage and in which a bona fide employer-employee relationship exists.

subscriber

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

Summary of Accumulation (SOA)

A statement received by a member that describes the services they've received and what amounts have been applied to the deductible and out-of-pocket maximum.

Summary of Benefits and Coverage (SBC)

Under the ACA, all health benefit companies and employers must provide plan subscribers and their dependents with a condensed listing of their benefits and coverage in a standardized format designed by the Department of Health and Human Services. The SBC allows your employees to easily compare plans and understand their coverage.

termination

The act of ending health coverage for a group or an individual member. Meaning, an individual or group no longer meets the eligibility requirements or has voluntarily requested coverage to end.

waiting period

The length of time that must pass before coverage of an individual, who's otherwise eligible to enroll, can become effective.

workers' compensation

A system whereby an employer must pay, or provide health benefit coverage to pay, the lost wages and medical expenses of an employee who's injured on the job.

Notes

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