Underwriting Guidelines

Kaiser Foundation Health Plan, Inc.
Kaiser Permanente Insurance Company

For businesses with 1 to 100 employees
Effective January 1, 2023

TABLE OF CONTENTS

TABLE OF CONTENTS

SECTION 1 – Introduction

If you have any questions, please contact your new business Group Sales Team at **800-789-4661, option 2.**

These are guidelines to Kaiser Permanente's general approach to evaluating and offering coverage to small business accounts. We want to keep you informed about our current underwriting guidelines; however, this document may be subject to change without notice as permitted under the law. The most current *Underwriting Guidelines* can be found on the broker section at **account.kp.org**.

These guidelines aren't intended to be all-inclusive. Other policies and guidelines may apply.

The final decision to accept or decline a group for coverage, specify terms of coverage, or grant requests for changes is contingent upon applicable authorization from Kaiser Permanente small group underwriting, subject to applicable law.

Brokers aren't authorized to bind or guarantee coverage, rates, or effective dates. All prospective businesses should maintain their current coverage until notified by Kaiser Permanente of approval for coverage.

AFFORDABLE CARE ACT (ACA) PLANS AND COVERAGE

Many options are available for health care through the ACA.

Metal plans

- Metal levels and benefits.

  The metal plans fit into 4 main levels of coverage. Each level has a different actuarial value:*

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

  These 4 categories offer different levels of copays, coinsurance, and deductibles for essential health benefits. For example, bronze plans have lower premiums with higher out-of-pocket costs, while other metal plans have higher premiums and lower out-of-pocket costs.

  *Actuarial value is the percent that the health plan will pay based on the claims of a standard population. The ACA allows a difference of +/- 2 points for actuarial value percentage.

  Benefit information for all our plans is available at kp.org/smallbusinessplans/ca.

Essential health benefits

For plan years beginning on or after January 1, 2014, the ACA requires all small group commercial plans[1] (with some exceptions, such as retiree and dental-only plans) to cover 10 categories of essential health benefits, as defined by ACA regulations:

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

For more information on child dental, go to page 25.

[1]Excludes grandfathered (nonmetal) plans.
[2]Pediatric vision is embedded in the medical plan.

SECTION 2 – Eligibility

California small group law includes the California Small Group Reform Act of 1992 (AB 1672), and has been amended as set forth in the California Health and Safety Code commencing with Section 1357.

To qualify for any Kaiser Permanente health plan coverage on a guaranteed-issue basis, an employer must meet and continue to meet certain requirements. These requirements are defined in the ACA, the California small group law, and in Kaiser Permanente's group eligibility requirements.

EMPLOYER ELIGIBILITY

- An employer that meets the employer eligibility requirements under the ACA and under the California Small Group regulations is eligible for guaranteed issue and guaranteed renewal under a small group health plan.
- An employer must have at least one but no more than 100 full-time and full-time-equivalent (FTE) employees for at least 50% of its working days for the previous calendar quarter or previous calendar year.
    - A full-time employee is a permanent employee actively engaged in the conduct of business on a full-time basis. It doesn't include a sole proprietor or their spouse, and a partner or their spouse. A full-time employee must have a normal workweek averaging 30 hours per week over the course of a month, work at the employer's regular place of business, be subject to withholdings on a W-2 form, and have met their waiting period, if applicable.
    - FTE employees are a combination of employees, each of whom individually isn't a full-time employee (because they're not employed on average at least 30 hours per week) but who, in combination, are counted as the equivalent of a full-time employee.

For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to the California Small Group Law (1357.500)(k)(3) or your legal counsel.

- An employer must have at least one W-2 employee (not including the sole proprietor owners, partners, their spouses or legal domestic partner).
- An employer must ensure that at least 50% of eligible employees are enrolled in a valid health plan.
- Affiliated companies under common control are required to enroll together unless they're not eligible to file a combined tax return for the purposes of state taxation. Affiliated companies eligible to file a combined tax return for purposes of state taxation are considered one employer even if they're not presently filing together.
- The employer must have a workers' compensation policy when required by law. Out-of-state based companies with employees hired in California must also have a California workers' compensation policy.

For Corporations and LLC's only: a corporate officer is considered a W-2 or common-law employee when on payroll. The officers can be husband and wife, domestic partners, or unrelated.

Business location:

- An employer must maintain business licensure and/or appropriate state filings allowing the business to conduct business in California.
- If an employer's business is located outside of California, or in California but outside the Kaiser Permanente service area, only employees living in our service area (based on their home ZIP+4 code) will be eligible for coverage.

Coverage requirements:

- An employer must offer health plan coverage to 100% of its eligible employees. Carve-outs aren't permitted.
- The business must not have been formed primarily for the purpose of buying a health plan or coverage.

EMPLOYEE ELIGIBILITY

To be eligible as a *full-time employee*, a person is required to be a permanent employee who isn't a spouse or legal domestic partner of a sole proprietor owner or partner who's actively engaged and regularly scheduled on a full-time basis in the conduct of the business of the small employer with a normal workweek averaging 30 hours, through the small employer's regular places of business.

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 employer.

- Employers can choose to offer coverage to employees working an average of 30 hours a week or at least 20 hours a week.

To be eligible as a *part-time employee* (as defined under SB 1790), a person must be an active, permanent employee who's actively engaged in the conduct of the business of the small employer working at least 20 hours but not more than 29 hours per a normal workweek, at the small employer's regular places of business. An employer **isn't required** to offer coverage to part-time employees, but can do so, provided that eligibility requirements are met. If coverage is offered to one or more part-time employees, then coverage must be offered to all part-time employees working at least 20 or more hours per week.

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

In addition to the eligibility rules above, full-time and part-time employees must:

- Receive monetary compensation for their work.
- Be a bona fide employee of the employer. Contracted or 1099 employees aren't eligible.
- Satisfy any applicable employer-imposed eligibility waiting periods.

In addition to the employee eligibility rules above, enrolling proprietors, partners, or corporate officers must:

- Draw wages, dividends, or other distributions from the business on a regular basis.

Minimum age:

- All subscribers, with the exception of an emancipated minor, must be 18 years old as of the customer's contract effective date. Kaiser Permanente won't enroll an employee under 18 as a subscriber, unless they're an emancipated minor.

Minors:

- Documentation of emancipated minor status is required if the subscriber will be under 18 as of the customer's contract effective date.
- Unemancipated minors can be included as subscribers when the group indicates they're eligible for coverage, provided a parent or guardian signs. The parent/guardian can sign on the subscriber line and indicate they're the parent or guardian of the unemancipated individual.

If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. For more information about Employer Shared Responsibility, see section 4980H(c)(2) of the Internal Revenue Code.

An employee has the option of enrolling as a subscriber or a dependent in certain circumstances (for example, a husband and wife working for the **same** business), but not a subscriber and a dependent in this situation.

Groups that fall into the following criteria may be ineligible for group coverage until all requirements are satisfied. Categories include, but aren't limited to:
-Termination due to the recertification process (groups must satisfactorily complete the recertification requirements). (See the "Re-enrollment" section for additional details).

Dependent eligibility

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

- 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 legal domestic partners who meet the employer group's eligibility requirements for domestic partnerships. A spouse who's covered as an employee of the same Kaiser Permanente group plan as the subscriber isn't allowed to also enroll as a dependent.
- An employee's or a spouse's children (including adopted or placed for adoption children) who are under age 26.
- Children (not including foster children) for whom the employee or spouse is the court-appointed guardian (or was when the person reached age 18) if they're under age 26.
- Children whose parent is a dependent under the employee's family coverage (in other words, eligible grandchildren of the subscriber), including adopted children or children placed with the employee's dependent for adoption, but not including foster children, if they meet **all** of the following requirements:
    - They're under age 26.
    - They're not married and don't have a domestic partner.
    - They receive all of their support and maintenance from the employee or spouse.
    - They permanently live with 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.

INELIGIBLE CATEGORIES

The following employer classifications are ineligible employers. Employers with classifications not listed below may also be ineligible if they fail other requirements. The absence of a category in this list doesn't make it eligible by default.

- *Associations* — Groups of nonaffiliated, separate employer entities banded together, unless the group meets the definition of a guaranteed association and has been actively in business since January 1987.
- *Multiple employer trusts* — Employers brought together under a master contract issued to a trustee under a trust agreement for the purpose of providing coverage.
- *Union trust plans* — Union employees under a labor trust fund in which the employer contributes to the fund but doesn't own the master contract.

- *Owner only* (Sole Proprietorship or Partnership) — Groups that don't have a bona fide employee on payroll, enrolling with Kaiser Permanente or other group health plan.
- *Taft-Hartley groups* — Groups participating in trusts established under the authority of the Labor Management Relations Act of 1948. Group contracts for coverage are issued to the trustees representing one or more unions and/or employers, usually in connection to collective bargaining agreements.
- *Retirees* — Former employees who may be eligible for retiree benefits if offered by the employer after meeting age and other requirements.
- *Hour bank groups* — Taft-Hartley welfare funds where employees meeting specific work-hour requirements can elect to put excess hours into the fund.
- *Contracted employees (1099)* — Employees providing contracted services and who typically receive 1099 forms for income taxes.
- *Seasonal, temporary, and substitute employees* — Employees who aren't hired on a permanent basis or who have a planned termination date.
- *Other ineligible classifications* — Private households, domestic help, members of organizations (such as credit unions and fraternal order members), conservatorships, embassies, and family trusts.

RE-ENROLLMENT AND REINSTATEMENT

Re-Enrollment

If your coverage was terminated (by the group or health-plan), then you may request a new effective date for coverage to re-enroll as a new group provided you qualify for small group coverage. A new group number and contract will be issued.

Reinstatement

For groups where your Kaiser Permanente coverage was terminated for less than 60 days, you may request reinstatement of your prior contract to avoid a gap in coverage. Kaiser Permanente will consider this request provided unpaid premiums are paid and you qualify for small group coverage.

California small group legal requirements include the ACA and the California small group law.

An employer must provide proper documentation to prove it qualifies as a small business under California state law. The documentation required by Kaiser Permanente is highlighted in the "New group-enrollment checklist" below and further detailed in the "Business and proof of ownership documentation" section. Keep this checklist handy to make sure your clients have all the forms and documents they need for their submission, plus the initial premium payment. Visit **account.kp.org** to download the most current versions of our forms.

An employer is required to demonstrate that it's been in business for at least 4 weeks with at least one but no more than 100 full-time and full-time-equivalent employees. An employer is eligible for Kaiser Permanente's guaranteed issue and guaranteed renewable small group health plans when the requirements are met and continue to be met under the ACA and under the California Small Group legal requirements.

Special rules and policies apply for groups breaking away from a business under an existing Kaiser Permanente contract. See "Breakaway/Spin-off groups" in the "Requirements for other group categories" section for details.

NEW GROUP ENROLLMENT CHECKLIST

To better serve you and your clients' needs, submit completed new groups prior to the first business day of the effective-date month. **Late submissions and incomplete or missing information will delay processing for your new groups.**

The most current versions of the following documents are required for new group submissions. Go to **account.kp.org** for the most current forms or to use the forms validation matrix tool to verify you're using the most current version. Type or use black ink for legibility; print neatly. Brokers will email completed submissions to **KPSBUBrokerNewGroups@kp.org**. For assistance, call **800-789-4661.**

Determining Group Size: DE 9C with 100+ employees

To qualify for small group coverage, the business must have at least one but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or 50% of the previous calendar year.

- The business can qualify with the previous calendar quarter DE 9C **or** the previous calendar year; only 2 quarters need to be submitted and they don't need to be consecutive.
- In determining whether to apply the calendar quarter or calendar year test, use the test that ensures eligibility if only one test would establish eligibility.

☐ **Employer Application**

- Complete the application, including the signature of the authorized contract signer or interested party and date of the signature.
- Complete all broker information.

☐ **Business eligibility documentation**

Examples of this documentation include, but aren't limited to, a current/active business license, a fictitious business name (FBN) statement, or Secretary of State (SOS) web record. Documentation is based upon the business entity type. See section 4, "Business and proof of ownership documentation," for details.

☐ **Employee Enrollment forms**

All eligible enrolling employees must complete this form and submit it to their employer for processing. Make sure all employees make copies for their records.

Employee Enrollment forms are included in the Employee Enrollment Kits and can also be downloaded at **account.kp.org**.

☐ **Declination documentation**

Employers are to complete the Declination of Coverage form for all eligible declining employees and keep the form for their records. **Please don't submit this form to Kaiser Permanente.**

☐ **First month's premium payment**

Complete the Electronic Transfer for Payment form for the first month's payment with the option to set up recurring autopay (recommended). Ensure the form is completely filled in to avoid processing delays; don't include a blank or voided check. The initial payment is processed within 5 to 7 business days of contract activation.

Kaiser Permanente Small Business doesn't accept credit card payments for coverage premiums.

SECTION 4 – Business and proof of ownership documentation

The documentation collected is used to help verify that a prospective customer is an active, legitimate small business eligible for small group coverage. The information is also used to demonstrate that an owner, officer, or partner is actively engaged in the business and eligible for coverage. Kaiser Permanente will conduct applicable state and local online searches to validate filings and other documentation. A group may not be approved for coverage if a search is unsuccessful.
Submit the most current documents to avoid processing delays.

Existing groups are periodically recertified to ensure business and ownership requirements are still being satisfied. As regulations, policies, and industry practices evolve, existing groups may be held to new standards. Kaiser Permanente staff will perform internal checks to confirm the business structure prior to processing the group.

Note: Kaiser Permanente reserves the right to request additional information.

SOLE PROPRIETORSHIP

A sole proprietorship is ineligible for enrollment without a W-2 employee. Owner, spouse, or legal domestic partner doesn't constitute an employee.

Kaiser Permanente will only recognize a single owner for a sole proprietorship as defined by the IRS.

Required documents

Business and ownership documents — submit one item from bulleted list:

- Current California business license.*
- Fictitious business name filing.

*A business tax certificate is acceptable for unincorporated areas not required to issue a business license.

SOLE PROPRIETORSHIP (HUSBAND/WIFE OR LEGAL DOMESTIC PARTNER) ELECTING TO BE A QUALIFIED JOINT VENTURE

Qualified joint venture owners, spouses, or legal domestic partners are ineligible for enrollment without a W-2 employee. Owner, spouse, or legal domestic partner doesn't constitute an employee.

For a sole proprietorship in which the husband and wife are co-owners of the business and elect to file taxes as a qualified joint venture:

Required documents

Business and ownership documents — submit one item from the bulleted list below:

- Current California business license
- Fictitious business name filing

Kaiser Permanente, at its sole discretion, reserves the right to request additional documentation to substantiate the employer/employee relationship and to assess the adequacy of documentation submitted.

SECTION 4 – Business and proof of ownership documentation

A corporate officer is considered a W-2 or common-law employee when on payroll. The officers can be husband & wife, domestic partners or unrelated.

CORPORATION

Required documents

California Secretary of State (kepler.sos.ca.gov) web confirmation.

OUT-OF-STATE (FOREIGN) CORPORATION

Required documents

1. California Secretary of State (kepler.sos.ca.gov) web confirmation with jurisdiction.
2. Required when the California web confirmation is unavailable — submit one of the bulleted items as an alternative:
   - Web confirmation with jurisdiction from the home state.
   - Statement and Designation by Foreign Corporation **and** Certificate of Good Standing from the home state.
   - Certificate of Qualification from the CA Secretary of State.

General partners, limited partners, and limited liability partners are ineligible for enrollment without a W-2 employee.

GENERAL PARTNERSHIP (GP) OR LIMITED LIABILITY PARTNERSHIP (LLP)

Required documents

Business documentation — submit one or more of the following:

- Statement of Partnership Authority (filed).
- State-certified application to register an LLP.
- Partnership Agreement* **and** the federal Employer Identification Number (EIN) assignment letter or any other government-issued document that shows the group's EIN.

*If Partnership Agreement isn't filed, additional documentation is required: business license or FBN.

OUT-OF-STATE (FOREIGN) LIMITED LIABILITY PARTNERSHIP (LLP)

Required documents

Both items below are required:

- Registration Form #LLP-1 Application for Registration.
- Certificate of Good Standing from the home state.

Owners and spouses, partners, or legal domestic partners of officers don't qualify as a W-2 employee.

LIMITED PARTNERSHIP (LP)

Limited partners must be on the DE 9C and/or payroll to be eligible for coverage.

Required documents

California Secretary of State (kepler.sos.ca.gov) web confirmation.

Kaiser Permanente, at its sole discretion, reserves the right to request additional documentation to substantiate the employer/employee relationship and to assess the adequacy of documentation submitted.

Owners and spouses, partners, or legal domestic partners of officers don't qualify as a W-2 employee.

OUT-OF-STATE (FOREIGN) LIMITED PARTNERSHIP (LP)

Required documents

1. California Secretary of State (kepler.sos.ca.gov) web confirmation with jurisdiction.
2. Required when the California web confirmation is unavailable — submit one of the bulleted items as an alternative:
   - Web confirmation with jurisdiction from the home state.
   - Registration Form #LP-5 Application for Registration **and** Certificate of Good Standing from the home state.

A corporate officer is considered a W-2 or common-law employee when on payroll. The officers can be a husband and wife, domestic partners, or unrelated.

LIMITED LIABILITY COMPANY (LLC)

Required documents

California Secretary of State (kepler.sos.ca.gov) web confirmation.

OUT-OF-STATE (FOREIGN) LIMITED LIABILITY COMPANY (LLC)

Required documents

1. California Secretary of State (kepler.sos.ca.gov) web confirmation with jurisdiction.
2. Required when the California web confirmation is unavailable:
   - Web confirmation with jurisdiction from the home state.

NONPROFIT

Per IRS Publication 557, in the "Organization Reference Chart" section, there are different types of 501c organizations, such as:

- 501c3 — Religious, educational, charitable, scientific, literary, testing for public safety, etc.
- 501c1 — Corporations organized under Act of Congress (including federal credit unions).

Required documents

Business documentation — submit one of the following to validate nonprofit status:

- California Secretary of State (kepler.sos.ca.gov) "active" web confirmation (nonprofit).
- National Federal Credit Union "active" web confirmation (nonprofit).
- IRS letter 501c3.
- IRS application for exempt status.

Kaiser Permanente, at its sole discretion, reserves the right to request additional documentation to substantiate the employer/employee relationship and to assess the adequacy of documentation submitted.

NATIONAL BANK CHARTER AND FEDERAL CREDIT UNION

Incorporated at the Federal level and regulated by the Office of the Comptroller of the Currency (OCC), a bureau of the U.S. Treasury.

Required documents

Web confirmation from the Federal Deposit Insurance Corporation website for National Bank Charters or the National Credit Union Administration website for Federal Credit Unions.

Kaiser Permanente, at its sole discretion, reserves the right to request additional documentation to substantiate the employer/employee relationship and to assess the adequacy of documentation submitted.

PARTICIPATION

- The employer must comply with the health plan's participation requirements and ensure that at least one W-2 employee (not including the sole proprietor owners or their spouses, partners or their spouses, or legal domestic partners) enrolls in Kaiser Permanente or other group health plan. Owners should include themselves in the eligible employee counts and group size count.
- **The employer must ensure that at least 50% of eligible employees are enrolled in a valid health plan.** For purposes of calculating participation, the following are considered valid health plan waivers:
    - Covered by another employer's health plan through a spouse, domestic partner, or parent
    - Covered by another health plan offered by this employer
    - Covered by another employer they work for
    - Group coverage through COBRA or Cal-COBRA
    - Covered by Medicare, Medi-Cal, or TRICARE (military or VA benefits)
    - Covered by an individual health plan

  Other types of health plan coverage may qualify as a valid health plan. Kaiser Permanente reserves the right to determine what coverage is considered valid health plan coverage.
- Employees who aren't eligible for coverage, including those who haven't satisfied the employer-imposed waiting period (the employer may waive the waiting period only at the start of a new group contract), are excluded from the participation percentage calculation. Waiting period is determined by the employer and in accordance with applicable laws.
- The employer agrees to inform its employees of the availability of coverage, and that a refusal of coverage will preclude enrollment until the group's next anniversary or an employee's qualifying event, unless employer meets certain special enrollment guidelines.

WRITING ALONGSIDE OTHER CARRIERS

Kaiser Permanente Small Group permits our coverage to be written alongside another carrier's coverage ("sliced") only if that other coverage is a fully insured, age-rated, ACA-compliant small group metal or grandfathered (nonmetal) health plan.

Plan types that don't qualify to be sliced and can't be written alongside our coverage are non-ACA plans, composite rated plans, level-funded or self-funded plans or association health plans (AHPs), including coverage issued for an AHP regulated by the California Department of Insurance.

CONTRIBUTIONS BY EMPLOYER

- Employers must contribute to all health coverage offered through the employer on a basis that doesn't financially discriminate against Kaiser Permanente or against people who choose to enroll in a Kaiser Permanente plan. The contribution can be a percentage or a fixed dollar amount.
    - Minimum contribution must be at least 50% of the employee's premium for the lowest-priced Kaiser Permanente medical plan offered by the employer (not including ancillary coverage).
    - When Kaiser Permanente is offered alongside another carrier, all contributions must be equitable.
    - Owners aren't required to contribute to dependent coverage.

GUARANTEED AVAILABILITY

The federal law requiring guaranteed availability of coverage provides that small business employers can't be denied coverage for failure to satisfy minimum participation or contribution requirements. There are no exceptions to guaranteed availability based on a minimum contribution or participation requirements, but the law permits a health plan or insurer to limit enrollment in coverage to open and special enrollment periods. If a small business employer doesn't meet contribution or minimum participation requirements, a health plan or insurer can limit its offering of coverage to an annual open enrollment period, which is the period from November 15 through December 15 of each year. Groups who enroll during this time are flagged for recertification and subject to termination upon their renewal if the underwriting criteria aren't met.

HSA/HRA FUNDING

- If a member is enrolled in a deductible plan with a health savings account (HSA) or health reimbursement arrangement (HRA), the group's contribution must be equitable amongst employees and when offered alongside another carrier.
- Refer to our plan highlights for minimum contribution requirements for HRA.

POLICY EFFECTIVE DATE

Policy effective dates are always the first of the month.

- Final rates are based on actual group enrollment for a specific policy effective date. A new rate quote may be required for a change or postponement of a policy's effective date. Rates may vary by policy effective date.
- Existing employees and their dependents (if the employer offers dependent coverage) are eligible for coverage on the employer's effective date.
- An employer group can make a plan change up to the 30th day following the group's effective date.
    - A plan change request received by the 15th of the effective month can be applied retroactively to the first of the month.
    - A plan change request received after the 15th of the effective month is applied to the first of the following month.

WAITING PERIODS

If the employer establishes a waiting period, the following criteria must be met:

- It's the employer's responsibility to ensure that the group doesn't apply a waiting period of more than 90 days (in accordance with the ACA).
- Employers can require new employees to complete an orientation period as long as it's no greater than 30 days. Any waiting period would begin to run only after completion of the orientation period. It's the employer's responsibility to administer and track these requirements.
- The effective date of coverage for new employees and their eligible dependents is always on the first of the month and it can't exceed the maximum 90-day waiting period.

CALIFORNIACHOICE® OR COVERED CALIFORNIA COVERAGE

- Kaiser Permanente doesn't write in slice position along CaliforniaChoice or Covered California. Kaiser Permanente is offered as an option within these exchanges.

STATEWIDE EMPLOYERS

Kaiser Permanente contracts with employers separately as Kaiser Foundation Health Plan, Inc., Northern California Region and Kaiser Foundation Health Plan, Inc., Southern California Region. If Kaiser Permanente provides coverage for a group's employees residing in both Northern and Southern California, then separate regional contracts may be issued based on the following rules:

- The employer's home region is typically the headquarters or main location, and is validated with business documentation.
- If 6 or more covered subscribers reside in the non-home region, then separate north and south contracts are issued (rates are based on the headquarter's location for both Northern California and Southern California contracts). Both contracts will be assigned unique group ID numbers.
- If an existing group grows to 13 or more subscribers in the non-home region, then separate north and south contracts are issued at renewal (rates are based on headquarter location for both Northern California and Southern California contracts).

EMPLOYERS WITH UNION AND NON-UNION EMPLOYEES

Group size is based on all eligible employees. When union members aren't permitted to enroll in a Small Business plan, they're **not** counted in group size. Participation requirements are based on the employees who are permitted to enroll with Kaiser Permanente.

- The total number of employees must be 1 to 100 full-time and full-time-equivalent employees in order to be eligible for small group coverage.
- Employers who own the union contract and don't pay into the union trust fund must enroll the entire group of union and non-union employees.
- When union employees receive health coverage through the union trust fund established by a collective bargaining agreement, then only non-union employees are eligible for Kaiser Permanente small group coverage. The employer is required to submit:
    - o Current contribution of wages report (itemized), also referred to as a monthly roster.

AFFILIATED COMPANIES

Affiliated companies under common control are required to enroll together unless they're NOT eligible to file a combined tax return for purposes of state taxation.

Business entities that are affiliated and eligible to file a combined tax return for purposes of state taxation will be considered one employer (even if filing separately or have a new/separate tax ID number) and must apply as one employer. The following documentation can be used to show affiliation:

- Employer Application employer eligibility question.
- Statement from CPA/tax attorney (existing groups undergoing recertification).

If a company isn't eligible to file a combined tax return, they'll be written as a separate customer. Kaiser Permanente will make the final determination of whether there's one responsible employer and may require additional documentation in order to do so.

BREAKAWAY/SPIN-OFF GROUPS

Breakaway vs. Spin-off

A breakaway has different ownership. A spin-off has common ownership.

A **breakaway or spin-off** business is a business that is newly formed from employees of an existing business to become a distinct and separate entity. Employees forming this business are no longer employed by the original business and are applying for coverage under a new contract.

A breakaway or spin-off employer must meet all the qualifications for a small business to be accepted for Kaiser Permanente Small Business coverage.

- If the breakaway or spin-off businesses are still affiliated and can file a combined tax return, then the companies are treated as a single business and are written under the same contract. The group is still considered to be a single business even if the businesses choose to file separate tax returns.
- For a breakaway or spin-off from an existing Kaiser Permanente small or large group, the business will move to a metal plan.
- For all existing Kaiser Permanente breakaways, the original employer remains with Kaiser Permanente on the existing contract, while the breakaway employer receives a new group number.
- A breakaway or spin-off group loses the grandfathered status of the existing group.

Affiliated businesses eligible to file a combined tax return **and** breaking away from an existing Kaiser Permanente group don't qualify as a new group. For additional assistance please contact your Account Manager or call **800-790-4661, option 3** to speak with our Small Business Services, Account Management Support team.

PROFESSIONAL EMPLOYMENT ORGANIZATIONS (PEOs)

Groups Using a PEO — Subject to the conditions listed below, Kaiser Permanente may agree to treat individuals covered by a co-employment agreement with a PEO as eligible employees of a California group for purposes of issuing a contract and enrollment:

- A California group must satisfy the small group size requirement (1-100 eligible employees) by combining directly employed and co-employed individuals.
- To be considered eligible employees, co-employed individuals may only be enrolled in the group health plan offered by the group, not the group health plan offered by the PEO. The small employer may not allow co-employees to choose between its coverage or the PEO's coverage.
- The group must employ the co-employed individuals on a full-time basis.
- The group must meet KP's small group underwriting guidelines.
- The group's enrollees may be listed on either the group's DE 9C (for direct employees) or the PEO's (for co-employees). If the group enrolls co-employees reported on the PEO's DE 9C, the group must provide the following documents in addition to standard required documents:
    - A copy of the group's PEO payroll sub-group or invoices for the last 3 months, showing PEO and sub-group name and co-employed individuals.

      OR
    - A copy of the group's PEO payroll sub-group and invoices for 2 weeks for start-up groups, showing PEO and sub-group name and co-employed individuals.
- The group may not offer its co-employed individuals both its small group coverage and coverage through the PEO. However, the group may offer Kaiser Permanente small group coverage alongside small group coverage offered by another Issuer that isn't available through the PEO.

Groups Breaking-Away from a PEO — The group must submit all of the following:

- Breakaway business documentation (e.g. business, license, etc.) (see *New Group Eligibility Guide* for document options).
- A letter on group letterhead or from the PEO (or email from the group) explaining that it's terminated its agreement with the PEO.
- A copy of the group's PEO payroll sub-group or invoices showing PEO subgroup name and co-employed individuals for 2 weeks (for employees not appearing on the groups DE 9C).

A group breaking-away from a PEO with Kaiser Permanente grandfathered coverage won't be able to obtain a grandfathered (nonmetal) plan.

TOTAL REPLACEMENT (TR)

A TR is achieved when Kaiser Permanente becomes the sole health coverage carrier of a small business by replacing all alternate carriers.

Required documentation

New group documentation, including prior carrier's current bill. Refer to Section 4, "Business and proof of ownership documentation" for detailed information.

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

MULTIPLE PLAN OPTIONS

Groups are eligible to offer a choice of medical plans to their employees.

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

PPO plan may be offered in Multiple Plan Options and only available if we are the sole carrier.

KAISER PERMANENTE HEALTH PAYMENT ACCOUNTS

If a group chooses to offer an HSA-qualified High Deductible Health Plan (HDHP) or a deductible HMO with HRA and would like Kaiser Permanente to administer the HSA or HRA, please contact a Kaiser Permanente representative for more information on setting up the account. Setup may take up to 20 business days.

DEDUCTIBLE CREDIT AND CARRYOVER

- We don't offer credit for expenses paid by members toward deductibles or out-of-pocket maximums in a medical or dental plan they had with another carrier prior to joining Kaiser Permanente.
- All deductible and out-of-pocket maximum accumulations for Kaiser Permanente reset to $0 on the start of the calendar year. No accumulations are carried over from the previous calendar year to the new calendar year.
- Deductible and out-of-pocket maximum accumulations will reset if a group is issued a new group number — for example, if you move your coverage from Kaiser Permanente to Covered California for Small Business or a private exchange, or from Covered California for Small Business or a private exchange to Kaiser Permanente.

HRA ADMINISTRATION, SETUP, AND FUNDING

- Groups are responsible for identifying an administrator if they don't choose Kaiser Permanente as their HRA administrator.
- Groups are responsible for all setup and ongoing fees.
- Groups selecting a deductible HMO with HRA plan must fund this plan for each enrolled employee. The allowable funding range is $100 to $400 per employee. If the group covers dependents, the allowable funding range per family is $200 to $800.
- Self-employed individuals and their families aren't eligible to enroll in an HRA plan, as stated in IRS Code Section 105(b). Employees of LLC, partnership, sole proprietorship, and S-corporation business types are eligible to enroll in an HRA plan.

Note
Benefit details for all our plans are available at **kp.org/smallbusinessplans/ca**.

PPO

- Kaiser Permanente Insurance Company (KPIC) plans (PPO) can be sold alongside any Kaiser Foundation Health Plan, Inc. (KFHP), products (HMO, DHMO, DHMO w/HRA, HSA-qualified HDHP).
- The minimum group size is one enrolling subscriber.
- Kaiser Permanente must be the sole carrier for all medical coverage.
- The PPO plans must be offered to all eligible employees.

If a company has 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.

Employees are responsible for deciding if participating provider physicians and facilities meet their needs. Employees can search for available providers and facilities at **multiplan.com/kaiser**.

METAL PLANS

Copay HMO plans — A copay is the fixed dollar amount paid for certain covered services or prescriptions. Copay plans feature mostly set fees and no deductible, so a member knows in advance how much they'll pay for services like doctor's office visits and prescriptions.

Deductible HMO plans — A deductible is the set amount that must be paid for most covered services within a plan year before a member's health plan begins to pay. When a member reaches their deductible, they'll start paying a copay or coinsurance (a percentage of the full charges) for most covered services for the rest of the plan year until they reach their out-of-pocket maximum. Depending on the plan, a member may pay copays or coinsurance for some services without having to reach their deductible.

HSA-qualified High Deductible Health Plan (HDHP) — These deductible HMO plans can be paired with a health savings account (HSA) administered through Kaiser Permanente,[1] giving your employees the option to open an HSA. They can contribute pretax or tax-deductible dollars[2] to the HSA and use that money to pay for qualified medical expenses. For a complete list of qualified medical expenses, see IRS Publication 502, *Medical and Dental Expenses*, at irs.gov/publications.

[1]Kaiser Permanente administration onboarding process may take up to 20 business days.

[2]Tax references relate to federal income tax only. Consult with your financial or tax adviser for information about state income tax laws. Federal and state tax laws and regulations are subject to change.

Deductible HMO with HRA plan — This deductible plan is paired with a health reimbursement arrangement (HRA), which the employer will set up for their employees. The employer contributes money into the employees' HRAs, which they can use to pay for the health care services they receive. Because this money isn't considered part of their wages, they won't pay federal income taxes on it.[3]

[3]Tax references relate to federal income tax only. Consult with your financial or tax adviser for information about state income tax laws. Federal and state tax laws and regulations are subject to change.

PPO plans — These plans give you referral-free access to contracted physicians or any other licensed provider of choice.

CHIROPRACTIC/ACUPUNCTURE

HMO plans - services are administered by American Specialty Health Plans of California, Inc. (ASH Plans).

PPO plans - services are administered by Private Healthcare Systems (PHCS).

Note
Benefit details for all our plans are available at **kp.org/smallbusinessplans/ca**.

CHILD DENTAL

- All metal HMO and PPO plans cover the ACA-defined essential health benefits, which include child dental services.
- HMO members are enrolled in a separate child dental plan underwritten by Delta Dental of California.
- PPO members receive child dental benefits as part of their medical coverage and not as a separate plan.
- Child dental services apply to all members under 19 years old. If a child turns 19 before the current contract renews, coverage is extended until the contract renewal date.

SUPPLEMENTAL FAMILY DENTAL PLANS (OPTIONAL)

- Family dental plans can only be purchased when the group first enrolls or at renewal.
- Family dental plans are only available to those enrolled in a Kaiser Permanente medical plan.
- When a family dental plan is offered, 100% of subscribers and dependents must enroll.
- Dental plans can be offered with just the richest plan(s) or with all plans.
- Additional family dental plan policies:
    - The DeltaCare HMO family dental plan isn't offered with any PPO medical plans.
    - The KPIC Fee-for-Service (Premier) Plan E with Ortho family dental plan requires a minimum of 10 subscribers.
    - Our family dental plans cover the entire family, including adults and dependent children up to age 26 (if the employer offers dependent coverage). However, they're not a substitute for the child dental coverage required by ACA regulations for members under 19 years old.

Rates for statewide employers are based on headquarter location for **both** Northern California and Southern California contracts. Rate changes only occur at renewal even when the group updates their address midyear. Proof of headquarter address may be required. (See Statewide employer businesses section for information on when separate contracts are required).

GENERAL RATING INFORMATION

Plan rates include many variables, such as benefit costs associated with the delivery of health care for all our small group customers as a whole. Rates are adjusted according to rating factors applicable to the plan type — grandfathered (nonmetal) or metal. Final rates are based on actual group enrollment. They're **guaranteed for 12 months** and are valid only from the effective date contained in the group contract.

The rate calculation for ACA-compliant metal plans is different from grandfathered (nonmetal) plans.

Metal plan rating

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

- **Rating area:**
  - If the business is located inside California, rates are based on the physical address (ZIP code and county) of the business.
  - If the business is located outside California, the group is assigned to rating area 4.
  - A post office box or other purchased address can't be used as the business's address. If we discover that a group is using an address other than the business's physical location, we may rescind or terminate their coverage.
- **Member age:**
  - Each family member has a separate rate based on his or her 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.
  - If a family has more than 3 children under age 21, the premium for each additional child after the third will be $0.
  - Age bands are 0–14, 15, 16, 17, 18, 19, 20, every age from 21 to 63, and 64+.
  - 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.

Rate calculations for statewide employers are identical for both regions. Rate changes only occur at renewal even when the group updates their address midyear. Proof of headquarter address may be required. (See "Statewide employer" section for information on when separate contracts are required).

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 in a California service area, rates are based on the physical address (ZIP code) of the employer's business.
  - If the business is located outside of California, or outside a California service area, rates are based on the ZIP code where the highest number of covered employees reside.
  - A post office box or other purchased address can't be used as the business's address. If we discover that a business is using an address other than the business's physical location, we may rescind or terminate their coverage.

- **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 will be 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 are:
    - 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):**
  - We apply one RAF to all grandfathered (nonmetal) plans. RAFs are 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. Extensive studies have shown that the types of prescriptions for chronic illness used by a group's plan members are an accurate predictor of the group's future medical utilization.

SECTION 9 – Existing business guidelines

The majority of the underwriting guidelines in previous sections have applied to both new and existing Kaiser Permanente groups. This section is designed to give brokers an overview of the underwriting guidelines as they pertain to plan changes for existing employer groups. This includes enrolling new employees, dealing with recertification and renewal, and making changes to an existing policy.

Grandfathered (nonmetal)

- If an employer's 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.
- Grandfathered (nonmetal) plans aren't required to meet some of the guidelines outlined by the ACA, such as essential health benefits and some preventive services.
    - This means they can continue offering their employees the same plan at their renewal.
- Employers also have the option of moving from their grandfathered (nonmetal) plan to one of our ACA-compliant metal plans.
    - If an employer chooses to move to one of our metal plans, they can purchase their Kaiser Permanente coverage through us, you (the broker), Covered California for Small Business, or through CaliforniaChoice. You can learn more at **coveredca.com/forsmallbusiness**. For information on CaliforniaChoice, visit **calchoice.com**.
    - Please note that if an employer chooses to move to one of our metal plans, they won't be able to go back to their current grandfathered (nonmetal) plan after they leave it.

Metal

For information on ACA plans and coverage, refer to pages 1 and 2.

SECTION 9 – Existing business guidelines

GROUP SIZE

An existing group may grow beyond the small business size threshold and remain in small business. It's the group's responsibility to determine its group size, factoring in full-time and full-time-equivalent employees. Kaiser Foundation Health Plan, Inc., reserves the right to require receipt of documentation.

Note: A minimum of 60 days advance notice prior to renewal is required to transfer a group from one business segment to another.

ENROLLMENT OPPORTUNITIES

Eligible employees and their eligible dependents can only enroll in the employer's health plan:

- During open enrollment.
- After satisfying the employer-imposed new hire waiting period.
- Within 60 days of becoming eligible to enroll through a qualifying event (e.g., birth, adoption, marriage, etc.).
- As part of a new pool of eligible employees:
    - Currently enrolled employees are allowed to change plans during the open enrollment period for new eligible employees when due to a documented merger/acquisition.
    - Employees previously declining coverage can't enroll until the next normal open enrollment.

RETROACTIVITY

For purposes of this section, termination means that an individual no longer meets the group's eligibility requirements or has voluntarily requested coverage to end.

All subscriber terminations will be effective in the month that we receive the termination request, unless it's requested that the termination be effective in a future month. For example, if a group wants the subscriber's coverage to be terminated effective August 1, we must receive the request to terminate no later than August 31. A termination request received in August can't be made effective retroactively back to July 1 or June 1.

A group can still add subscribers or dependents and have the coverage effective retroactively up to 2 months prior to the current month. For example, a group has until August 31 to add members with a coverage effective date of June 1.

OPEN ENROLLMENT

Once a year, employers must give employees the opportunity to change plans or add dependents. Employees and/or dependents who don't enroll when first eligible can't enroll until the annual open enrollment period. However, employees may be eligible to enroll themselves and their dependents before the next open enrollment period if a qualifying event, such as losing other coverage, occurs.

MEDICAL PLAN CHANGES

Renewal

At renewal, a group can choose to change plans. This includes replacing a plan or adding a plan with richer benefits, which generally has a higher premium than the employer's current plan. The number of plans that a group is allowed to offer is based on enrolled subscribers.

- An employer can only make a plan change if the account is current.
- An employer must submit change requests to Kaiser Permanente Small Business on or before the last business day of the renewal effective month. Change requests must contain an email date, postmark, or fax date stamp to prove the change was submitted on time.
    - o A plan change request received by the 15th of the effective month by 5 p.m. (PT) is effective the first of the month.
    - o A plan change request received between the 16th and the last business day of the month by 5 p.m. (PT) of the effective month is effective the first of the following month.
    - o Deductible accumulation amounts may not be transferable.

MULTIPLE PLAN OPTIONS
Groups are eligible to offer a choice of medical plans to their employees.
Groups with 1 to 5 enrolled subscribers can offer a choice of up to 4 HMO Kaiser Permanente plans plus 1 PPO plan for a maximum of 5 plans.
Groups with 6 or more enrolled subscribers can offer a choice of 1 or more HMO Kaiser Permanente plans plus 2 PPO plan.

Midyear plan changes

A plan change made outside of the renewal that results in a short contract less than 12 months is considered a midyear plan change. Restrictions apply to midyear plan changes. Requests are granted if the requirements under the Midyear downgrades/replacements and Midyear upgrades/downgrades, found in this section 9, are satisfied. However, Kaiser Permanente reserves the right to decline midyear plan changes of any type. The following rules apply to both midyear downgrades and upgrades:

- A plan change request received by the 15th of the effective month by 5 p.m. (PT) is effective the first of the month, or a future effective month.
- A plan change request received between the 16th and the last business day of the month by 5 p.m. (PT) is effective the first of the following month.
- Deductible accumulation amounts may not be transferable.
- The ACA requires the employer to provide Summary of Benefits and Coverage (SBC) documents for midyear plan changes (material modification to health coverage options) to employees and their dependents at least 60 days before the new plan's effective date. As such, an attestation is required for health coverage changes.

See Crossover Guidelines for HMO and Deductible Plans in this section 9.

Midyear downgrades/replacements

An employer is allowed to replace an existing plan with a plan with less rich benefits and lower premiums outside of the renewal if these conditions are met:

- Employees aren't allowed to remain on the plan that is being replaced.
- An employer can make one midyear downgrade during the policy year.
- Changes aren't permitted during the contract freeze period 120 days before the renewal date.

Downgrade due to financial reasons

Groups with high/low plans in place can:

- Replace the high plan with a plan in between the high and the low and transfer all members from the high plan to the new plan.
- Replace the lowest plan offered with a lower plan and transfer all members from the low plan to the new plan (this scenario would mean there are still members in the high plan).
- Replace the high plan with the existing low plan and transfer all members from the high plan to the low plan.
- Replace both plans with a downgraded plan; members are transferred to the downgraded plan.

Midyear plan additions due to mergers/acquisitions

For groups with high/low plans in place:

- Enrollment is available to the new pool of eligible employees and existing employees via a special open enrollment.
- A richer plan above the highest plan available can be added, and members can enroll in the new plan or remain on the current plan.
- A richer plan above the highest plan available can be added, and members may choose between all plans.

Midyear upgrades/downgrades

An employer is only allowed in very limited situations to add/replace an existing plan with a richer benefit plan, and this requires underwriting approval. Plan upgrades can only be made midyear for the following reasons:

- **New pool of eligibles:** An employer with a new pool of eligible employees (mergers/acquisitions) can add a Kaiser Permanente plan that closely matches the new pool of employees' existing plan(s), including plan designs richer than currently offered by the employer. A copy of the billing or face sheet showing the new eligibles' previous plan(s) is required to verify prior coverage. Existing and new employees hired after the new plan has been added can select from all plans offered.
- **Total replacement:** A plan can be added and offered to the subscribers and dependents who don't currently have Kaiser Permanente coverage if and when Kaiser Permanente becomes the employer's sole health carrier.

CROSSOVER GUIDELINES FOR HMO AND DEDUCTIBLE PLANS

For groups making a plan change, please review the Crossover scenarios.

Sometimes business needs require employers to change their benefit coverage in the middle of an accumulation period. This can raise questions about whether or not employees' credits toward the deductible and out-of-pocket maximum (OOP maximum) cross over to the new plan. This guide clarifies when these credits transfer to the new plan and when they reset to $0. It applies to the following plan types:

- HMO
- HMO with coinsurance
- Deductible HMO
- Deductible HMO with HRA
- HSA-qualified HDHP HMO

Resets in the middle of an accumulation period

Under normal circumstances, the deductible and OOP maximum reset to $0 on a member's accumulation period start date. However, certain plan changes made at other times will also reset a member's deductible credits to $0 when the new plan takes effect. When this happens, the OOP maximum will also reset to $0. Here are the 2 most common reasons why a member's credits would reset to $0:

- **A group is issued a new group number —** for example, a company consolidates or is acquired, or it transfers to or from CaliforniaChoice or Covered California.
- **A member moves to an individual plan** from a group plan (or vice versa).

Crossover scenarios for HMO plans

The following table highlights the 4 most common situations where a plan is changed in the middle of an accumulation period.

For more information and to get additional plan change scenarios, please contact your Kaiser Permanente representative.

Do credits toward the deductible and OOP maximum cross over to the new plan?

Scenarios	HMO[1] to HMO	HMO[1] to HDHP HMO (HSA-qualified)[2] (or vice versa)	HDHP HMO (HSA-qualified)[2] 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[3]	Yes	Yes[3]
Employee changes employer	No	No	No
Individual plan member enrolls in a group plan	No	No	No

[1]HMO plans include HMO, HMO with coinsurance, deductible HMO, and deductible HMO with HRA.

[2]HSA-qualified plan refers to the HDHP HMO plan only.

[3]Members must request that accumulation credits be applied to their new plan by calling the Deductible Product Service Team at **800-390-3507.**

CHIROPRACTIC/ACUPUNCTURE PLANS (OPTIONAL) (FOR GRANDFATHERED [NONMETAL] PLANS ONLY)

Combined coverage for chiropractic/acupuncture care is included on the following ACA-compliant metal plans: Platinum 90 HMO 0/10 + Child Dental Alt, Gold 80 HMO 0/30 + Child Dental Alt, Gold 80 HMO 1000/40 + Child Dental Alt, Silver 70 HMO 1900/65 + Child Dental Alt, Silver 70 HMO 2300/65 + Child Dental Alt, Silver 70 HMO 2800/65 Child Dental Alt, and the Bronze 60 HMO 5400/60 + Child Dental Alt with the cost of the benefits embedded in the medical plan rate.

- Chiropractic/Acupuncture coverage provides members up to 20 combined visits per year for a copay of only $15 per visit.
- Chiropractic/Acupuncture plans aren't available with our HSA plans. If a group chooses chiropractic/acupuncture coverage, all subscribers and dependents must participate, except for out-of-state employees, who are only eligible for the chiropractic/acupuncture plan offered with the PPO plans.
- Groups can discontinue their current chiropractic/acupuncture coverage anytime up to 4 months before the renewal date, or at renewal.
- Groups can add a new chiropractic/acupuncture plan only at renewal.

FAMILY DENTAL PLANS

Family dental plans can only be added or changed when the employer initially signs up for Kaiser Permanente coverage or at renewal. An employer is generally allowed to drop its family dental plan midyear. However, Kaiser Permanente reserves the right to decline requests to drop a family dental plan midyear.

INFERTILITY BENEFIT (OPTIONAL)

The optional infertility benefit is available only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier.

- This benefit is added to all the HMO plans offered, when selected.
- All metal PPO plans include the infertility benefit.
- Groups can only add or discontinue this benefit upon renewal, if it isn't selected as part of the original contract.

RENEWAL

Notification

The standard renewal date is 12 months from the contract effective date and is always on the first of the month. A renewal notice is provided:

- To groups at least 60 days before their contract renewal effective date.
- To brokers approximately 75 days before the contract renewal effective date.

Renewal contracts are issued within 60 days following the contract renewal effective date. If a renewing group chooses to make changes to its current plan offering, then a renewal contract reflecting the changes will be provided shortly after processing is completed.

Renewal date change

Kaiser Permanente grants limited exceptions for renewal date changes upon underwriting review. Requests won't be considered to align with a dental plan, life insurance plan, or FSA/HSA HMO funding arrangement.

Group implications:

- An employer will receive a rate increase if the renewal date change results in the renewal date falling within a new rate period.
- For grandfathered (nonmetal) plans only, an employer's RAF can be adjusted if the employer changes to a new renewal date that is at least 6 months later than the current renewal date.

RECERTIFICATION

Employer groups will periodically be required to recertify that the group continues to meet eligibility requirements as a small business, that employees are eligible and have a bona fide employee relationship, and that all other applicable underwriting guidelines are satisfied.

If a group is using a post office box, UPS store address, or other purchased address, rather than the physical location of the business in question, your group won't be recertified unless a physical address is provided.

A group that doesn't pass recertification or is unresponsive to recertification requests is subject to termination.

REINSTATEMENT

If a former customer's contract is terminated for less than 60 days, the former group can be reinstated. When a group is reinstated there's no lapse in coverage.

- The customer retains its prior group number.
- The customer's renewal date is the same date the customer had prior to the termination.
- The customer retains their grandfathered status.

All reinstatement requests must be approved by a manager.

TRANSFERS BETWEEN CALIFORNIA REGIONS

Kaiser Foundation Health Plan, Inc. (KFHP), is divided into 2 regions in California: Northern California and Southern California. An employer can change regions anytime (not just at renewal).

Contact your Kaiser Permanente representative for additional details.

- An employer must advise Kaiser Permanente when it moves its headquarters to a new California region by submitting an Address Change Request Form.
- The group is rated again upon renewal.

STATEWIDE EMPLOYERS

Kaiser Permanente contracts with employers separately as Kaiser Foundation Health Plan, Inc., Northern California Region and Kaiser Foundation Health Plan, Inc., Southern California Region. If Kaiser Permanente provides coverage for a group's employees residing in both Northern and Southern California, then separate regional contracts may be issued.

- The employer's location is typically considered the home region.
- If an existing group grows to 13 subscribers in the non-home region, then separate north and south contracts are issued at renewal (rates are based on headquarter location for both Northern California and Southern California contracts).

CHANGE OF OWNERSHIP

Contact your Account Manager or Account Management Support Team representative as soon as there is a change of ownership. There are specific documents required. They will walk you through the process.

- Changes submitted after 5 p.m. (PT) are considered received the next business day. Fax changes to **800-369-8010** or email **amt@kp.org**.

Example:

- A change request received from an employer (via fax or email) by April 15 takes effect on April 1.
- A request received on or after April 16 takes effect on May 1.

Contract changes may be subject to Small Business management approval.

CAUSES FOR TERMINATION

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

- The employer intentionally fails to enforce employee and dependent eligibility rules.
- The employer fails to pay required premiums after the grace period has lapsed.
- The employer fails to comply with underwriting requirements, including participation or contribution standards.
- The employer commits an act of fraud or intentional misrepresentation of material fact.
- The employer has no employees enrolled in a Kaiser Permanente small business plan.
- The employer 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.

Coverage of an employee or dependent can be terminated or rescinded if the individual directly or indirectly commits an act of fraud or intentional misrepresentation of material fact.

BINDING ARBITRATION

For a comprehensive arbitration fact sheet, visit **account.kp.org** > Working with Kaiser Permanente > Compliance

Since we use binding arbitration, the state of California requires us to notify applicants at the point of enrollment. We're also required to capture applicants' signatures during that enrollment process to confirm that they've read and agreed to our binding arbitration.

Employees/applicants must be informed of Kaiser Permanente's use of binding arbitration when 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 can lead to quicker dispute resolutions.

Compliance with state law and ensuring that employees/applicants are properly informed depends on how enrollments are collected:

If enrollments are collected using a current Kaiser Permanente enrollment form: The enrollment process is in compliance as long as the employer is using a relatively new version of our form that includes a current version of our binding arbitration notice. If you're not sure how old the enrollment form is, please contact the Small Business Services, Account Management Support Team at **800-790-4661, option 3.**

If enrollments are collected using your own form (a universal form): As long as your form includes our most current arbitration notice and it's been approved by Kaiser Permanente's regulatory department, your enrollment process is in compliance. We recertify universal forms on an annual basis; please contact the Small Business Services, Account Management Support Team at **800-790-4661, option 3.**

If enrollments are collected using an online enrollment website: California Arbitration Management System (CAMS), is a web service that can be added to an enrollment website. The functionality can be added at any point within your enrollment site as long as it appears before the subscriber/enrollee completes the enrollment process. Our technical and business team will work with administrators (brokers, employer groups, TPAs) to understand system requirements and ensure compatibility.

FEDERAL

- **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.

STATE

- Cal-COBRA (SB 719) became effective January 1, 1998. This legislation provides for the continuation of coverage for employees and eligible dependents for groups that employed fewer 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 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.