

Underwriting guidelines for brokers and producers

Kaiser Foundation Health Plan, Inc.
Kaiser Permanente Insurance Company

For businesses with 1 to 100 employees
Effective January 1, 2017

This information is not intended to constitute legal advice and should not be relied upon in lieu of consultation with appropriate legal advisers.

TABLE OF CONTENTS

1. INTRODUCTION	1
What types of plans do your groups have?.....	1
2. GETTING STARTED	3
Group-enrollment checklist	3
Start-up groups.....	5
3. BUSINESS AND PROOF OF OWNERSHIP DOCUMENTATION	6
Sole proprietorship.....	6
Sole proprietorship (husband/wife or legal domestic partner) electing to be a qualified joint venture.....	7
Corporation.....	8
Out-of-state (foreign) corporation.....	8
General partnership (GP), or limited liability partnership (LLP)	9
Out-of-state (foreign) limited liability partnership	9
Limited partnership (LP)	10
Out-of-state (foreign) limited partnership (LP)	10
Limited liability company (LLC).....	11
Nonprofit	11
4. ELIGIBILITY	12
Employer eligibility.....	12
Employee eligibility.....	13
Ineligible categories.....	14
5. GENERAL UNDERWRITING GUIDELINES	16
Participation	16
Guaranteed availability	16
Contributions by employer.....	17
Policy effective date	17
Waiting periods.....	18
6. REQUIREMENTS FOR OTHER GROUP CATEGORIES	19
Statewide employer groups.....	19
Employer groups with union and nonunion employees	19
Affiliated companies.....	19
Breakaway/Spin-off groups.....	20
Professional employment organizations (PEOs)	21
Total replacement.....	21

TABLE OF CONTENTS

7. PLAN REQUIREMENTS	22
Multiple plan option rules	22
Kaiser Permanente Health Payment Accounts	22
Deductible funding policy	22
HRA administration, setup, and funding	22
PPO plans	23
Metal plans	23
Child dental	24
Deductible and out-of-pocket accumulation credits	24
Chiropractic/acupuncture	24
Family dental plans (Optional)	25
Infertility benefit	25
8. RATING POLICY	26
General rating information	26
9. EXISTING BUSINESS GUIDELINES	28
Group size	28
Enrollment opportunities	28
Retroactivity	28
Open enrollment	29
Medical plan changes	29
Crossover guidelines for HMO and deductible plans	31
Family dental plans	32
Chiropractic/acupuncture plans (for grandfathered [nonmetal] plans only)	32
Infertility benefit	33
Renewal	33
Recertification	33
Transfers between California regions	34
Contract change requests	34
Causes for termination	34
Binding arbitration	35
10. FEDERAL AND STATE REGULATIONS	36
Federal	36
State	38

If you have any questions, please contact your Account Manager or call **800-790-4661, option 3**, to speak with our Small Business Services, Customer Connection Team.

These guidelines represent Kaiser Permanente’s general approach to evaluating and offering coverage to new and existing small business accounts. This document is designed to keep you informed about our current underwriting guidelines; however, it may be subject to change without notice as permitted under the law. The most up-to-date *Underwriting Guidelines* can be found on the broker section at account.kp.org.

These guidelines are not 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 Business underwriting, subject to applicable law.

Brokers are not authorized to bind or guarantee coverage, premium rates, or effective dates. All prospective businesses should be advised to maintain their current coverage until notified by Kaiser Permanente of approval for coverage.

WHAT TYPES OF PLANS DO YOUR GROUPS HAVE?

Many options are available for health care through the Affordable Care Act (ACA). To understand those options, it’s important to know what kinds of plans employers currently offer — grandfathered (nonmetal) or ACA-compliant metal plans.

Grandfathered (nonmetal)

- If an employer’s plan has covered at least 1 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 plans

- Metal levels and benefits

The metal plans fit into 4 main levels of coverage. Each level has a different actuarial value — the percent that the health plan will pay for covered essential health benefits based on the claims of a standard population:*

- 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.

*The ACA allows a difference of +/- 2 points for actuarial value percentage.

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

- Essential health benefits

Plan years beginning on or after January 1, 2014, the ACA requires all small group commercial plans* (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[†]

For more information on child dental, go to page 24.

*Excludes grandfathered (nonmetal) plans

[†]Pediatric vision is embedded in the medical plan.

SECTION 2 – Getting started

California Small Group legal requirements include the California Small Group Reform Act of 1992 (AB 1672), as amended by AB 1083, set forth in the California Health and Safety Code commencing with Section 1357.500 or 1357.600.

A new group 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 “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.

A new group is required to demonstrate that it has been in business for at least 6 weeks with at least 1 but no more than 100 full-time and full-time-equivalent employees. A new group 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.

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. Use black ink for legibility. Brokers will fax completed submissions to their sales associate. For assistance, call **800-789-4661**.

New Group Application

- Complete the application, including the signature of the authorized company officer and date of the signature.
- Complete all broker information.
- Indicate your group’s contract delivery method.

Business/Owner eligibility documentation

Examples of this documentation include, but are not limited to, a current/active business license, a fictitious business name (FBN) statement, a Statement of Information, or tax documents. Documentation is based upon the business entity type. See section 3, Business and proof of ownership documentation, for details.

Employee Enrollment forms

All eligible enrolling employees must complete sections 2 through 4 of 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 may also be downloaded at account.kp.org.

Declination documentation

Each eligible employee who declines coverage through their employer must complete and sign the Declination of Coverage form except for employee(s) enrolled with an alternate carrier offered through their employer. For these employees, an annotation on the DE 9C may be made in lieu of the Declination of Coverage form.

DE 9C Quarterly Wage Report and/or payroll reports

All groups with *eligible employees* for 6+ months are required to provide the most recent DE 9C filing that shows a full quarter of data. Companies with eligible employees for 6 weeks to 6 months may submit payroll records. Submit the New Employee Eligibility Documentation form for employees hired in the last 30 calendar days, who cannot be verified with at least 2 weeks of payroll records, on or before the effective date of coverage. Reconcile the DE 9C quarterly wage report if the group has less than 10 eligible employees.

No need to reconcile the DE 9C* quarterly wage report if:

- The group has 10 or more eligible employees listed on the NGA
- The group's DE 9C lists 10 or more employees
- You collect a combination of 10 or more employee applications or declination forms from the group. **Note:** Slice groups may submit less than 10 applications since we do not collect declination forms for slice groups.

*Payroll is accepted for **start-ups only** — not in combination of or in lieu of the DE 9C.

Proprietor/Partner/Corporate Officer Eligibility Statement (if applicable)

Each proprietor, partner, or corporate officer who is not listed on the DE 9C completes and signs this form.

First month's premium payment

Complete the Electronic Transfer for Initial Payment form for the first month's payment. As an alternative, the group may submit a copy of a business check in the amount of the first month's premium and payable to Kaiser Permanente along with the New Group Application.

Kaiser Permanente Small Business does not accept credit card payments for small business insurance premiums.

Once an employer group has been approved, we'll provide a mailing address for submitting the original check or debit the account provided for the premium amount, depending on which option has been chosen.

Please note that the authorization for payment by electronic check applies only to the first payment.

SECTION 2 – Getting started

Payroll may be submitted in lieu of a DE 9C for start-up companies in business 6 weeks to 6 months or for substantiated companies previously without employees.

START-UP GROUPS

Kaiser Permanente considers start-up groups that have been in business for at least 6 weeks.

- Start-up groups are required to provide payroll records and other applicable documents, depending on the filing status, indicating the length of time the group has been in business. These documents must cover the 6 weeks preceding the requested effective date and show 1 or more eligible employees for the entire period. Payroll records must include all pages for all pay periods and list the following:
 - Company name
 - Dates of pay periods
 - Employee names, wages paid, withholdings, and grand totals
- Individual pay stubs, estimated payroll, or handwritten journals are not acceptable.

SECTION 3 – Business and proof of ownership documentation

A sole proprietorship is ineligible for enrollment without a W-2 employee enrolling in Kaiser Permanente or another group health insurance plan. Owner, spouse, or legal domestic partner does not constitute an employee.

Payroll may be submitted in lieu of a DE 9C for start-up companies in business 6 weeks to 6 months or for substantiated companies previously without employees.

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.

The documentation collected is used to help verify that a prospective customer is an active, legitimate small group eligible for small business 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.

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.

SOLE PROPRIETORSHIP

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

Required documents

1. DE 9C and/or payroll
2. Business and ownership documents — submit 1 item from bulleted list:
 - Current California business license
 - Fictitious business name filing
 - Current Schedule C **and** 1040 form

Required if the owner is not on the DE 9C

3. Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

SECTION 3 – Business and proof of ownership documentation

Qualified joint venture owners, spouses, or legal domestic partners are ineligible for enrollment without a W-2 employee enrolling in Kaiser Permanente or another group health insurance plan. Owner, spouse, or legal domestic partner does not constitute an employee.

Payroll may be submitted in lieu of a DE 9C for start-up companies in business 6 weeks to 6 months or for substantiated companies previously without employees.

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.

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

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

1. DE 9C and/or payroll
2. Business and ownership documents — submit each bulleted item:
 - California business license **or** fictitious business name filing
 - California jointly filed current IRS 1040* with separate Schedule C/F

*Marriage license (*substitutes for IRS 1040 due to newly married*) with spouse Schedule C/F

Required if the owner is not on the DE 9C

3. Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

If a sole proprietorship (husband/wife or legal domestic partner) has 1 or more eligible employees and cannot meet the requirements above, then 1 spouse may enroll as a dependent and requirements for sole proprietorship apply. At time of recertification, a sole proprietorship (husband/wife or legal domestic partner) must meet the qualified joint venture requirements, including submission of separate Schedule C forms for husband and wife or legal domestic partner.

SECTION 3 – Business and proof of ownership documentation

Corporate officers are ineligible for enrollment without a W-2 employee enrolling in Kaiser Permanente or another group health insurance plan. A corporate officer who is not a single-owner, spouse, or legal domestic partner may be considered a W-2 or common-law employee when on payroll with deductions.

Payroll may be submitted in lieu of a DE 9C for start-up companies in business 6 weeks to 6 months or for substantiated companies previously without employees.

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.

CORPORATION

Required documents

1. DE 9C and/or payroll* **and** California Secretary of State (kepler.sos.ca.gov) "active" Web confirmation

If an officer is not on the DE 9C

2. Business and ownership documentation — submit 1 or more of the following to validate owners/officers:
 - Articles of Incorporation with Action by Incorporator
 - Articles of Incorporation
 - Statement of Information
 - Election by a Small Business Corporation (2553)
 - Tax Form 1120 (pages 1 and 2) with Schedule 1125E (for C Corp)
 - Schedule K-1 1120S (for S Corp)
3. Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

*Single-owners and spouses or legal domestic partners of officers or partners do not constitute the qualifying W-2 employee.

OUT-OF-STATE (FOREIGN) CORPORATION

Required documents

1. DE 9C and/or payroll* **and** California Secretary of State (kepler.sos.ca.gov) "active" Web confirmation with jurisdiction
2. Required when the "active" Web confirmation is unavailable due to processing delays — submit 1 of the bulleted items as an alternative
 - Statement and Designation by Foreign Corporation **and** Certificate of Good Standing
 - Certificate of Qualification
3. Officer validation — *each* document is required when an officer is not on the DE 9C
 - Statement of Information (Foreign) or tax documents
 - Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

*Owners and spouses or legal domestic partners of officers or partners do not constitute the qualifying W-2 employee.

SECTION 3 – Business and proof of ownership documentation

General partners, limited partners, and limited liability partners are ineligible for enrollment without a W-2 employee enrolling in Kaiser Permanente or another group health insurance plan.

Payroll may be submitted in lieu of a DE 9C for start-up companies in business 6 weeks to 6 months or for substantiated companies previously without employees.

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.

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

Required documents

1. DE 9C and/or payroll*
2. Business and ownership documentation — submit 1 or more of the following to validate partners not on the DE 9C:
 - Partnership Agreement[†] **and** the federal Employer Identification Number (EIN) assignment letter or any other government-issued document that shows the group's EIN
 - Schedule K-1 (1065)
 - Statement of Partnership Authority (filed)
 - State-certified application to register an LLP
3. Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

*Owners and spouses or legal domestic partners of officers or partners do not constitute the qualifying W-2 employee.

[†]If Partnership Agreement is not filed, additional documentation is required: business license or FBN.

OUT-OF-STATE (FOREIGN) LIMITED LIABILITY PARTNERSHIP

Required documents

1. DE 9C and/or payroll*
2. *Both* items below are required:
 - Registration Form #LLP-1 Application for Registration
 - Certificate of Good Standing
3. Business and ownership validation required when a partner is not on the DE 9C:
 - Partnership Agreement **or** tax forms to validate partners
 - Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

*Owners and spouses or legal domestic partners of officers or partners do not constitute the qualifying W-2 employee.

SECTION 3 – Business and proof of ownership documentation

Payroll may be submitted in lieu of a DE 9C for start-up companies in business 6 weeks to 6 months or for substantiated companies previously without employees.

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.

LIMITED PARTNERSHIP (LP)

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

Required documents

1. DE 9C and/or payroll **and** California Secretary of State (kepler.sos.ca.gov) "active" Web confirmation
2. Business and ownership validation — each bulleted item is required when a general partner is not on the DE 9C:
 - Certificate of Limited Partnership **or** Schedule K-1 (1065)
 - Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

*Owners and spouses or legal domestic partners of officers or partners do not constitute the qualifying W-2 employee.

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

Required documents

1. DE 9C and/or payroll* **and** California Secretary of State (kepler.sos.ca.gov) "active" Web confirmation with jurisdiction
2. Each item is required when the "active" Web confirmation is unavailable due to processing delays:
 - Registration Form #LP-5 Application for Registration
 - Certificate of Good Standing
3. Business and ownership validation, required when a general partner is not on the DE 9C:
 - Partnership Agreement **or** tax forms to validate partners
 - Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

*Owners and spouses or legal domestic partners of officers or partners do not constitute the qualifying W-2 employee.

SECTION 3 – Business and proof of ownership documentation

Limited liability company owners/officers/partners are ineligible for enrollment without a W-2 employee enrolling in Kaiser Permanente or another group health insurance plan.

Payroll may be submitted in lieu of a DE 9C for start-up companies in business 6 weeks to 6 months or for substantiated companies previously without employees.

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.

LIMITED LIABILITY COMPANY (LLC)

Required documents

1. DE 9C and/or payroll* **and** California Secretary of State ([kepler.sos.ca.gov](https://www.kepler.sos.ca.gov)) "active" Web confirmation
2. Business and ownership documentation to validate owner(s), officer(s), or partner(s) not on the DE 9C or payroll — submit 1 or more appropriate documents:
 - LLC treated as Sole Prop (see #2, pages 6 and 7[†])
 - LLC treated as Corp (see #2, page 8[‡])
 - LLC treated as Partnership (see #2, page 9[‡])
3. Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement *for owners, officers, or partners not on the DE 9C and/or payroll*

*Single-owners and spouses or legal domestic partners of officers or partners do not constitute the qualifying W-2 employee.

[‡]Additional options include Articles of Organization with Operating Agreement, Articles of Organization, or appropriate tax documents.

[†]If nonprofit is a church, submit a DE 9C and/or payroll **and** a letter from the church for exempt employees with requisite information.

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

1. DE 9C and/or payroll*
2. Business documentation — submit 1 of the following to validate nonprofit status:
 - IRS letter 501c3
 - IRS application for exempt status
 - California Secretary of State ([kepler.sos.ca.gov](https://www.kepler.sos.ca.gov)) "active" Web confirmation (nonprofit)
 - National Federal Credit Union "active" Web confirmation (nonprofit)
3. Officer validation documents — *each* item is required when an officer is not on the DE 9C or payroll
 - Appropriate documents for nonprofit linking each officer to the company
 - Kaiser Permanente Proprietor/Partner/Corporate Officer (PPC) Eligibility Statement

*If nonprofit is a church, submit a DE 9C and/or payroll **and** a letter from the church for exempt employees with requisite information.

SECTION 4 – Eligibility

California Small Group legal requirements include the California Small Group Reform Act of 1992 (AB 1672), amended by AB 1083 (2012), 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, a group must meet the requirements defined under the “Employer Eligibility” and “Employee Eligibility” sections, and the type of group must not be included under the “Ineligible Categories” section.

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 1 but no more than 100 full-time and full-time-equivalent employees, which excludes spouses and owners, for at least 50% of its working days for the previous calendar quarter or previous calendar year.
 - Full-time employees are permanent employees actively engaged in the conduct of business on a full-time basis. They must have a normal work week averaging 30 hours per week over the course of a month, work at the employer’s regular place of business, be subject to withholding on a W-2 form, and have met their waiting period, if applicable.
 - Full-time-equivalent (FTE) employees are a combination of employees, each of whom individually is not 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.
- An employer must have a minimum of 1 W-2 employee (excluding the owner, spouse, or legal domestic partner) enrolling in Kaiser Permanente or another group health insurance plan.
- An enrolling proprietor, partner, or corporate officer who is not listed in the DE 9C completes and submits a Proprietor/Partner/Corporate Officer Eligibility Statement and other applicable documents from the “Business and Proof of Ownership Documentation” section.
- Spouses or domestic partners who work for the same employer have the option to enroll as separate subscribers, or one may enroll as a dependent under the other’s coverage.
- Affiliated companies under common control are required to enroll separately unless they’re eligible to file a combined tax return for the purposes of state taxation.
- In determining group size, affiliated companies eligible to file a combined tax return for purposes of state taxation are considered 1 employer even if they’re not presently filing together.

Company location:

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

Coverage requirements:

- An employer must offer health plan coverage to 100% of its eligible employees.
- Kaiser Permanente requires all employers to have a workers' compensation policy unless it is not required by law. Companies based out of state with employees hired in California must also have a California workers' compensation policy.
- The business must not have been formed primarily for the purpose of buying a health plan or insurance coverage.

EMPLOYEE ELIGIBILITY

To be eligible as a *full-time employee*, a person is required to be a permanent employee who is not a spouse, owner, or legal domestic partner who is 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.

- Employers may 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 is 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 is **not required** to offer coverage to part-time employees, but may do so, provided that eligibility requirements are met. If coverage is offered to 1 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 will not cover employees working less 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 (subject to withholdings)
- Be a bona fide employee of the employer
- 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 company on a regular basis
- Not derive substantial earned income from any other employer
- Not be eligible for other employer-sponsored coverage as a subscriber

SECTION 4 – Eligibility

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** company), but not a subscriber and a dependent in this situation.

Dependent eligibility

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 is covered for benefits as an employee of the same Kaiser Permanente group plan as the subscriber is not allowed to 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 do not have a domestic partner
 - They receive all of their support and maintenance from the employee or spouse
 - They permanently reside 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 does not apply to disabled dependents.

INELIGIBLE CATEGORIES

The following employer classifications do not meet California Small Group legal requirements standards as small businesses and 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 does not 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 insurance
- *Union trust plans* — Union employees under a labor trust fund in which the employer contributes to the fund but does not own the master contract

SECTION 4 – Eligibility

- *Owner only* — groups that do not 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 1 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
- *Leased/shared employees* — Employees whose wages are paid and taxes withheld by a different entity, such as professional employer organizations (PEO), and the group compensates the entity. The group does not have an employee/employer relationship.
- *Contracted employees (1099)* — Employees providing contracted services and who typically receive 1099 forms for income taxes
- *Seasonal, temporary, and substitute employees* — Employees who are not hired on a permanent basis or who have a planned termination date
- *Other ineligible classifications* — Private households, domestic help, single-employee companies, members of organizations (such as credit unions and fraternal order members), conservatorships, embassies, and family trusts

PARTICIPATION

- The employer must ensure that at least 70% of eligible employees are covered by a group health plan and that a minimum of 1 W-2 employee (excluding the owner, spouse, or legal domestic partner) enrolls in Kaiser Permanente or other group health plan. Owners do not count toward participation.
- An employee is considered to have group health plan coverage and count toward the 70% requirement when:
 - He or she enrolls in a Kaiser Permanente plan offered by the group.
 - He or she declines coverage due to other group coverage.
- Employees who are not eligible for coverage, including those who have not satisfied the employer-imposed waiting period, are excluded from the participation percentage calculation. Waiting period is determined by the employer.
- 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, unless employer meets certain special enrollment guidelines.
- When offering a PPO for metal plans, Kaiser Permanente must be the sole carrier for medical coverage.

GUARANTEED AVAILABILITY

The federal law requiring guaranteed availability of coverage provides that small business employers cannot be denied guaranteed availability of coverage for failure to satisfy minimum participation or contribution requirements. While there is no exception to guaranteed availability based on a minimum contribution or participation requirements, the law permits a health plan or insurer to limit enrollment in coverage to open and special enrollment periods. If a small business employer does not meet contribution or minimum participation requirements, a health plan or insurer may 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 are not met.

CONTRIBUTIONS BY EMPLOYER

- Employers must contribute to all health coverage offered through the employer on a basis that does not 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. For each family, the employer's contribution must be no less than the greater of the following amounts:
 - 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).
 - The highest amount the group would have contributed if this family had enrolled in any other carrier's plan offered by the group (not including ancillary coverage)
- If a member is enrolled in a deductible plan with a health savings account (HSA) or health reimbursement arrangement (HRA), the group's contribution to any HSA or HRA must be at least equal to the highest amount the employer would have contributed to that HSA or HRA if this family had enrolled in another carrier's plan offered by the employer.
- Employers are not required to contribute to dependent coverage.
- Groups selecting the Gold 80 HRA HMO 2000/30 + Child Dental (Deductible HMO with HRA plan) must fund this plan for each enrolled employee. The allowable funding range is \$250 to \$600 per employee. If the group covers dependents, the allowable funding range per family is \$500 to \$1,200.

POLICY EFFECTIVE DATE

- 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.
- Policy effective dates are always the 1st of the month.
- Existing employees and their dependents (if the employer offers dependent coverage) are eligible for coverage on the employer's effective date.
- An employer group may 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 may be applied retroactively to the 1st of the month.
 - A plan change request received after the 15th of the effective month is applied to the 1st of the following month.
 - Deductible accumulation amounts may not be transferable.

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 does not apply a waiting period in excess of 90 days in accordance with the ACA.
- Employers may require new employees to complete an orientation period as long as it is no greater than 30 days. Any waiting period would begin to run only after completion of the orientation period. It is the employer's responsibility to administer and track these requirements.
- The effective date of coverage for new employees and their eligible family dependents is always on the 1st of the month and it must not exceed the maximum 90-day waiting period.

SECTION 6 – Requirements for other group categories

STATEWIDE EMPLOYER GROUPS

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 necessary based on the following rules:

- The employer's location is typically considered the home region.
- If 6 or more covered subscribers reside in the nonhome region, then separate north and south contracts are issued (Rates are based on headquarter location for both Northern California and Southern California contracts).
- If 5 or less covered subscribers reside in the nonhome region, then a single contract for the home region is sufficient.
- A group growing to 13 or more subscribers in the nonhome region is required to contract with the other region at renewal (See General Rating Information on page 26 and 27 for metal and grandfathered [nonmetal] ratings; rate calculations are identical for both regions).

EMPLOYER GROUPS WITH UNION AND NONUNION EMPLOYEES

- The total number of both union and nonunion 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 do not pay into the union trust fund are eligible to enroll the entire group of union and nonunion employees.
- When union employees receive health coverage through the union trust fund established by a collective bargaining agreement, then only nonunion employees are eligible for Kaiser Permanente small group coverage. The employer is required to submit:
 - A copy of the collective bargaining agreement showing contributions to the trust fund.
 - The statement of ERISA rights from the union trust summary plan description.

AFFILIATED COMPANIES

Business entities that are affiliated and eligible to file a combined tax return for purposes of state taxation will be considered 1 employer (even if filing separately) and must apply as 1 employer. The following documentation can be used to show affiliation:

- New Group Application *Employer Eligibility* question.
- Statement from CPA/tax attorney (existing groups undergoing recertification)

Kaiser Permanente will make the final determination of whether there is 1 responsible employer and may require additional documentation in order to make a determination. If the companies are not eligible to file a combined tax return, they're written as separate customers.

Affiliated companies under common control are required to enroll separately unless they're eligible to file a combined tax return for purposes of state taxation.

BREAKAWAY/SPIN-OFF GROUPS

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

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

- If the breakaway companies are still affiliated and can file a combined tax return, then the companies are treated as a single company and are written under the same contract. The group is still considered to be a single company even if the companies choose to file separate tax returns.
- For a breakaway group new to Kaiser Permanente, breakaway employees can be noted on the DE 9C/payroll records of the original group in order to document employees. Provided that documents show the original group has been in business for more than 6 weeks, the breakaway group does not need to meet this requirement separately.
- For a breakaway from an existing Kaiser Permanente small or large group, the group 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 customer ID.

SECTION 6 – Requirements for other group categories

PROFESSIONAL EMPLOYMENT ORGANIZATIONS (PEOs)

- Employees associated with a PEO are employed by the business listing the employees on its DE 9C. A business leasing/sharing employees from a PEO cannot cover these employees under its Kaiser Permanente group coverage.
- For a PEO breakaway group that's new or existing to Kaiser Permanente, the group submits:
 - o A letter from the group stating that it will no longer be leasing employees from the PEO (the group may continue to use the PEO to provide administrative services)
 - o 6 weeks of payroll for leased employees from PEO
 - o Breakaway business documentation is still required (e.g. business license, etc.); see matrix for document options.
- A breakaway group from an existing Kaiser Permanente PEO will move to a metal plan.

TOTAL REPLACEMENT

A total replacement (TR) is achieved when Kaiser Permanente becomes the sole health insurance carrier of a small business by replacing 1 or more medical insurance plans offered by another carrier.

Required documentation

New group documentation, including prior carrier's current bill. Refer to Section 3, Business and proof of ownership documentation for detailed information.

MULTIPLE PLAN OPTION RULES

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

- Groups with 1 to 5 enrolled subscribers may offer a choice of up to 3 Kaiser Permanente plans.
- Groups with 6 or more enrolled subscribers may offer a choice of 1 or more Kaiser Permanente plans.

KAISER PERMANENTE HEALTH PAYMENT ACCOUNTS

If the 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 HRA or HSA, please contact a Kaiser Permanente representative for more information on setting up the account.

DEDUCTIBLE FUNDING POLICY

Groups that directly fund or reimburse employees for any Kaiser Permanente deductibles, coinsurance, or copays are in violation of our deductible funding policy and may be subject to termination or nonrenewal. This includes employer reimbursements of employee cost share through employee flexible spending accounts (FSAs) or limited purpose FSAs. Exceptions include:

- Employers who choose a Kaiser Permanente deductible HMO plan with HRA must contribute to their employees' HRA.
- Employers can fund an employee's HSA only if the employee is enrolled in an HDHP plan. Contributions must be made in accordance with federal tax laws for HSAs.
- Deductible funding restrictions do not apply to PPO plans.

Brokers who have advised small business clients to fund or directly reimburse employees for deductible plan expenses in violation of our policies will not receive sales commissions (or rewards compensation) from Kaiser Permanente.

HRA ADMINISTRATION, SETUP, AND FUNDING

- Groups are responsible for identifying an administrator if they do not choose Kaiser Permanente as their HRA administrator.
- Groups are responsible for all setup and ongoing fees.
- Groups selecting the Gold 80 HRA HMO 2000/30 + Child Dental plan must fund this plan for each enrolled employee. The allowable funding range is \$250 to \$600 per employee. If the group covers dependents, the allowable funding range per family is \$500 to \$1,200.
- Self-employed individuals and their families are not eligible to enroll in a 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 a HRA plan.

SECTION 7 – Plan requirements

PPO PLANS

- A group may not offer more than 1 PPO plan.
- KPIC (PPO) plans may be sold alongside any Kaiser Foundation Health Plan, Inc. (KFHP), products (HMO, DHMO w/HRA, DHMO w/HSA).
- The minimum group size is 1 enrolling subscriber.
- Kaiser Permanente must be the sole carrier for all medical coverage.
- The PPO plans must be offered to all eligible employees.

Employees are responsible for determining if participating provider physicians and facilities are sufficient to 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.

- Gold 80 HMO 0/30 + Child Dental
- Platinum 90 HMO 0/10 + Child Dental Alt
- Platinum 90 HMO 0/15 + Child Dental

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.

- Bronze 60 HMO 6300/75 + Child Dental
- Silver 70 HMO 1000/50 + Child Dental Alt
- Silver 70 HMO 2000/45 + Child Dental
- Gold 80 HMO 500/35 + Child Dental Alt

HSA-qualified High Deductible Health Plan (HDHP) — These deductible HMO plans can be paired with a health savings account (HSA) administered through Kaiser Permanente, giving your employees the option to open an HSA. They can contribute pretax or tax-deductible dollars* 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.

- Bronze 60 HDHP HMO 4800/40% + Child Dental
- Silver 70 HDHP HMO 2000/20% + Child Dental

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.

- Gold 80 HRA HMO 2000/30 + Child Dental

*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.

Groups selecting the Gold 80 HRA 2000/30 + Child Dental Deductible HMO with HRA plan must establish and fund an HRA for each enrolled employee. The allowable funding range is \$250 to \$600 per employee. If the group covers dependents, the allowable funding range per family is \$500 to \$1,200.

SECTION 7 – Plan requirements

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

- Bronze 60 PPO 6300/75 + Child Dental
- Silver 70 PPO 2000/45 + Child Dental
- Gold 80 PPO 0/30 + Child Dental
- Platinum 90 PPO 0/15 + Child Dental

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 0–18 years old.

DEDUCTIBLE AND OUT-OF-POCKET ACCUMULATION CREDITS

- Kaiser Permanente does not 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 credits for Kaiser Permanente reset to \$0 on the start of the calendar year. No credits are crossed over from the previous calendar year to the new calendar year.

Certain mid-accumulation period plan changes will also reset the deductible and/or out-of-pocket maximum credits to \$0 in the following situations:

- A group's customer identification number changes — for example, a company consolidates or is acquired, or it transfers to or from CaliforniaChoice or Covered California.
- A member moves their 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.

CHIROPRACTIC/ACUPUNCTURE

Combined coverage for chiropractic/acupuncture care is included with the following ACA-compliant metal plans:

- Platinum 90 HMO 0/10 + Child Dental Alt
- Gold 80 HMO 500/35 + Child Dental Alt
- Silver 70 HMO 1000/50 + Child Dental Alt

Services are administered by American Specialty Health Plans of California, Inc. (ASH Plans).

FAMILY DENTAL PLANS (OPTIONAL)

- Family dental plans can only be purchased when the group first enrolls or at renewal.
- Family dental plans are not available to subscribers who are not enrolled in a Kaiser Permanente medical plan.
- When a family dental plan is offered with a medical plan, 100% of subscribers and dependents must enroll.
- Dental plans may be offered with just the richest plan(s) or with all plans.
- Additional family dental plan policies:
 - The DeltaCare HMO family dental plan may not be 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 ages 0–25 (if the employer offers dependent coverage). However, they're not a substitute for the child dental coverage required by ACA regulations for members 0–18 years old.

INFERTILITY BENEFIT

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 may only add or discontinue the benefit upon renewal, if it is not selected as part of the original contract.

SECTION 8 – Rating policy

Rates for statewide groups 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.

GENERAL RATING INFORMATION

Plan rates take into account 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 area location and apply age bands. 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 are not used to determine member premium rates.

- **Rating area:**

- The rating area for metal plans, if the business is located in California, is based on the physical address (ZIP code and county) of the business.
- Groups located outside of California are assigned to rating area 4.
- A post office box or other purchased address may not 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 annually 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 0–18, 19–20, every age from 21 to 63, and 64+.
- All plans include child dental for members 0–18 years old as of the group contract effective date. HMO plans apply the cost of child dental only to the 0–18 age band. PPO plans spread the cost of child dental across all age bands.

SECTION 8 – Rating policy

Rate calculations for statewide groups 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.

Grandfathered (nonmetal) plan rating

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

- **Rating area:**

- The rating area for a grandfathered (nonmetal) plan, if a business is located in a California service area, is based on the physical address (ZIP code) of the employer's business.
- Businesses located outside of California, or outside a California service area, are rated based on the ZIP code where the highest number of covered employees reside.
- A post office box or other purchased address may not 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 1 child under 26, the premium for each additional child after the first will be \$0.

- **Risk adjustment factor (RAF):**

- We apply 1 risk adjustment factor (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 may not 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.

GROUP SIZE

An existing group may grow beyond the small business size threshold and remain in small business. It is 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 in order 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:
 - o Currently enrolled employees are allowed to change plans during the open enrollment period for new eligible employees when due to a documented merger/acquisition.
 - o Employees previously declining coverage may not enroll until the next normal open enrollment.

RETROACTIVITY

All subscriber terminations will be effective in the month that we receive the termination request, unless it is 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 cannot 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.

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.

OPEN ENROLLMENT

Once a year, employers must give employees the opportunity to change plans or add dependents not previously enrolled. Employees and/or dependents who do not enroll when first eligible may not enroll until the annual open enrollment period to enroll. 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 may 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 group size. See section 7, Plan requirements, for more details.

- An employer may 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.
 - A plan change request received by the 15th of the effective month may be applied retroactively to the 1st of the month, when requested.
 - A plan change request received after the 15th of the effective month is effective the 1st of the following month or a future effective month, when requested.
 - Deductible accumulation amounts may not be transferable.

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 may be applied retroactively to the 1st of the month, if desired, or a future effective month. A plan change request received after the 15th of the month is effective the 1st of the following month. Deductible accumulation amounts may not be transferable.
- A change in deductible HMO products may result in a loss of deductible and out-of-pocket accumulations for effective dates other than January 1. See Crossover Guidelines for HMO And Deductible Plans in this section 9.
- The Affordable Care Act (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.

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 are not allowed to remain on the plan that is being replaced.
- An employer can make 1 midyear downgrade during the policy year.
- Changes are not permitted during the contract freeze period 120 days before the renewal date.

Downgrade due to financial reasons

Groups with high/low plans in place may:

- 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 may be added, and members can enroll in the new plan or remain on the current plan.
- A richer plan above the highest plan available may 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 may 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 may select from all plans offered.
- **Total replacement:** A plan may 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.

SECTION 9 – Existing business guidelines

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

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

CROSSOVER GUIDELINES FOR HMO AND DEDUCTIBLE PLANS

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
- 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 3 most common reasons why a member's credits would reset to \$0:

- **A group's customer identification number changes** — 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).

SECTION 9 – Existing business guidelines

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.

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

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

*HMO plans include HMO, HMO with coinsurance, deductible HMO, and deductible HMO with HRA.

[†]“HSA-qualified plan” refers to the HDHP HMO plan only.

[‡]Members must request that accumulation credits be applied to their new plan by calling the Member Service Contact Center at **800-390-3507**.

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 500/35 + Child Dental Alt, and the Silver 70 HMO 1000/50 + Child Dental Alt with the cost of the benefits embedded in the medical plan rate. Optional chiropractic/acupuncture coverage is available for grandfathered (nonmetal) plans, except for POS and PPO plans (as these plans are no longer available), and HSA HMO-qualified plans.

FAMILY DENTAL PLANS

Family dental plans may 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.

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

- Chiropractic/Acupuncture coverage provides members up to 20 combined visits per year for a copay of only \$15 per visit.
- Chiropractic/Acupuncture plans are not 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 may 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.

INFERTILITY BENEFIT

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 may only add or discontinue the benefit upon renewal, if it is not 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 1st 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 will not 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 may 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 will not 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.

Groups terminated for longer than 60 days but less than 1 year, must provide Kaiser Permanente proof of active group coverage in order to re-enroll.

Please refer to our General Rating Information found in section 8.

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). 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 re-rated upon renewal.

An employer may have subscribers in both regions if there are less than 13 subscribers in one of the regions. The subscribers in the smaller region will then be administered under the contract for the primary region. However, if there are 13 or more subscribers in each region, the employer is required to establish separate contracts in each region.

CONTRACT CHANGE REQUESTS

New contract or renewal change requests will be accepted until the last day of the effective month for the effective date of the new employer group or renewing employer.

Midyear contract change requests are effective as follows:

- Changes submitted between the 1st and the 15th of the month may be effective the 1st of the same month or a future effective month, if desired.
- Changes submitted between the 16th of the month and the last business day of the month may be effective the 1st of the following month or a future effective month, if desired.
- Changes submitted on the 15th or on the last business day of the month must be received at Kaiser Permanente for small business by 5 p.m. Pacific time. Fax changes to **800-369-8010**.
- If the 15th or the last day of the month falls on a Saturday or Sunday, the fax is due to Kaiser Permanente the next business day.

Example:

- A change request received from an employer (via fax or email) by April 15th 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 may terminate coverage under any of the following conditions:

- The employer fails recertification and/or no longer qualifies for small business coverage.
- The employer fails to enforce employee and dependent eligibility rules.
- The employer is delinquent and does not pay the required premium.
- The employer fails to comply with underwriting requirements, including participation or contribution standards.
- The employer commits an act of fraud or misrepresentation.

SECTION 9 – Existing business guidelines

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

- The employer has no active employees enrolled in a Kaiser Permanente small business plan.
- The employer moves outside Kaiser Permanente's approved California service areas.
- The employer violates the Kaiser Permanente deductible funding policy.

Coverage of an employee or dependent may be terminated or rescinded if the individual directly or indirectly commits an act of fraud or misrepresentation.

BINDING ARBITRATION

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, Customer Connection 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 has 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, Customer Connection 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 may be added to an enrollment website. The functionality may 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

- **Federal TEFRA and DEFRA legislation** was enacted to regulate employee health coverage. Based on this legislation and the limitations of the Kaiser Permanente agreement, if a business employs on average less than 20 employees in a year, and any employee becomes age 65, then his or her primary health carrier must be Medicare. For these employees who are 65 years old and choose to retain their Kaiser Permanente small group coverage, Kaiser Permanente will apply contract benefits as a secondary carrier for Medicare benefits paid or payable. This applies whether or not the employee has applied for and has been made effective for Medicare Parts A and B coverage.
- When a member is covered by both Medicare as primary and a Kaiser Permanente contract as secondary, total benefits provided by Medicare and Kaiser Permanente should equal but not exceed the benefits of group members who do not have Medicare coverage.
- Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company are secondary to Medicare when either one of the following criteria are met:
 - The employer has less than 20 employees and the subscriber is age 65.
 - Subscribers under 65 are eligible for Medicare due to a disability.
 - Subscribers are enrolled following the first 30 months of kidney dialysis treatments for end-stage renal disease (ESRD).
- **COBRA:** Participation in the employer's health plan, as well as coverage under whatever medical programs are provided by the employer to employees and their dependents, may be continued under a federal law known as COBRA for groups that employ 20 or more employees for at least 50% of the previous calendar year.
 - The employer is responsible for administration (within the guidelines established by the federal government for compliance by employer groups).
 - Kaiser Permanente does not offer federal COBRA administration support.
- **ERISA status:** On July 23, 2010, the Departments of Labor, the Treasury, and Health and Human Services issued interim final regulations regarding claims and appeals procedures for group health plans to implement the requirements of the federal health care reform legislation. As part of Kaiser Permanente's efforts to answer federal and state regulatory inquiries regarding member's claims and appeals related to the new requirements, a group's Employee Retirement Income Security Act (ERISA) status must be verified. To ensure compliance, employer groups are asked to indicate their ERISA status initially on the New Group Application and then annually with the renewal notice to update Kaiser Permanente if the reported status is no longer valid.

SECTION 10 – Federal and state regulations

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

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

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

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

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

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 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 was not 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 are not 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:
 - o Death of the plan subscriber, for continuation of dependent coverage
 - o Employee's termination of employment or reduction in hours
 - o Spouse's divorce or legal separation from the subscriber
 - o Loss of dependent status of enrolled child
 - o Subscriber becoming entitled to Medicare
 - o 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 are not eligible for Cal-COBRA.