Small Group Administrative Handbook

A guide to managing your account

January 2022

MAKE THE MOST OF YOUR SMART DECISION

You've made an important investment in your business by offering your employees the convenience and care of Kaiser Permanente's better model of health coverage.

Now it's time to get an even better return on that investment by making sure you and your employees get the most out of everything we offer.

HERE'S HOW TO GET STARTED

1. Encourage your employees to register on **kp.org** and take advantage of our unique online services — like emailing their doctor's office with questions, checking most lab results, and ordering prescription refills. Tools that enable your employees to manage their health care online can help cut down on time away from work — and that means higher productivity.

2. Check out our online account services at **account.kp.org**. It's the easy, secure, time-saving way to manage your group health coverage. You can enroll employees, pay your premiums online, check the status of new changes to your account, and more. Just fill out the Primary Administrator Online Access Request form and fax it to us to get your user ID and password.

3. Read through this handbook and keep it as a reference. It contains important information on how to enroll and terminate employees and dependents, understand and pay your bills, as well as the forms you'll need to manage your plan.

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

Thank you for choosing Kaiser Permanente!

IMPORTANT RESOURCES

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1. THE BASICS

Where to find forms

kp.org/smallbusinessforms/ca

Where to send forms

Please be sure to include your company name and group ID on all correspondence.

For membership changes, COBRA forms, etc., fax, email or mail form(s) to:

Northern California accounts	Kaiser Permanente California Service Center P.O. Box 23219 San Diego, CA 92193-3219	**csc-sd-sba@kp.org**	**855-355-5334**
Southern California accounts	Kaiser Permanente California Service Center P.O. Box 23250 San Diego, CA 92193-3250	**csc-sd-sba@kp.org**	**855-355-5334**

For renewal changes, broker of record changes, plan changes or group termination, email or fax form(s) to:

Northern and Southern California accounts	**AMT@kp.org**	**800-369-8010**

Where to sign up for online payments (preferred method)

Our online account services is a fast, convenient way to view and pay your monthly bills.

Where to mail payments

Kaiser Foundation Health Plan
File #5915
Los Angeles, CA 90074-5915

Be sure to add your group number to your completed payment coupon and include the coupon with your payment. Payments without a payment coupon have to be processed manually, which delays crediting payments to your account.

Where to get answers to your small business services questions

Billing and Eligibility Small Business Services, California Service Center	
• Billing questions -Copies of bills -Nonpayment arrangements -Bill reconciliation questions • Membership status inquiries • Reinstatement • Schedule A-5500 form/report request	Phone: **800-790-4661, option 1** Email: csc-sd-sba@kp.org for: -Enrollment applications -Member terminations -Account changes All other requests should be faxed: Fax: **855-355-5334**
Employer/Broker Services Small Business Services, Client Services Unit	

• Benefit inquiries • Broker of Record change status • **account.kp.org** inquiries • COBRA interpretation • Contract/eligibility inquiries • Employer collateral -Enrollment material -Plan highlights -Rate sheets	Phone: **800-790-4661, option 2** Email: **csu.ca@kp.org** Fax: **800-369-8010**
Employer/Broker Account Administration Small Business Services, Account Management Support Team	
• Contact changes • Group address change • Midyear downgrade inquiries • Plan changes • Renewal changes • Group termination	Phone: **800-790-4661, option 3** Email: **amt@kp.org** Fax: **800-369-8010**

Online Resources		
account.kp.org (for employers) • Manage your account online • Download forms and publications • View wellness information	**account.kp.org (for brokers)** • Manage your client's account online • Download your client's renewal information • Download forms and publications • View wellness information • View commission	**kp.org (for members)** • Facility and physician locator • Guidebooks • Prescription refills • Plan and coverage information • Routine appointments

Hours for all departments: 8:30 a.m.–5 p.m. Pacific Time, Monday–Friday.

Please be sure to include your company name and group ID on all correspondence.

Where your employees can get information

Member Service Contact Center

Open 24 hours a day, 7 days a week. Closed holidays.

800-464-4000

711 (TTY)

800-788-0616 (Spanish)

800-757-7585 (Chinese dialects)

Where to file claims

Claims Administration – Northern California

P.O. Box 12923

Oakland, CA 94604-2923

Claims Administration – Southern California

P.O. Box 7004

Downey, CA 90242-7004

For further information, please call **800-390-3510.**

Where to get information on health care reform (HCR)

For the latest information on HCR, visit **kp.org/reformforsmallbusiness/ca**, **healthcare.gov**, or **kff.org**.

Where to get information on Medicare

For information on Medicare, please visit **kp.org/medicare**.

2. MEMBERSHIP ADMINISTRATION

Save time with free online account services

Account.kp.org, our online administrative home for employers and agents, makes it fast and easy to stay on top of administrative tasks. You'll have 24-hour access to membership and billing information so you can make updates whenever it's convenient.

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

For a tour of our online account services, go to **account.kp.org**.

How to register for online account services

1. Complete and sign a Primary Administrator Online Access Request form.
2. Fax the form to:

   855-355-5334

You can begin using our online account services as soon as you receive your user ID and password in the mail — usually within 7 days.

Once you receive your user ID, you can create additional user IDs for those you wish to also have access to the site, and you can vary their privileges according to their responsibilities. You'll find this function under the "Account Access" drop-down menu within the website.

Only those individuals you've designated on the Primary Administrator Online Access Request form will have access to your online account services information.

Note

Some transactions can't be completed online such as:

- Open enrollment plan changes
- Membership additions due to loss of coverage or court order

Questions about online account services?

Call online account services support at **800-893-2971.**

How to use online account services

1. Go to **account.kp.org**.
2. Enter your user ID and password and click on the "Sign In" box.
3. View the tutorial to get started.

- Name and address changes are effective immediately when you click the "Submit" button.
- Termination changes are effective on the first of the month. If the last day of employment is the first of the month, coverage will terminate on that date. Otherwise, coverage will terminate on the first of the following month.

Note

If you're updating your group contacts, please complete the Primary Administrator Online Access Request form in addition to the Contact Change Request form.

If the online system can't process your request for any reason, we'll attempt to process it manually by the end of the next business day. If we're unsuccessful, the request will appear as "rejected" in the online transaction history. If a transaction doesn't appear as "active" or "rejected" by the end of the next business day, please contact us.

Security

Protecting your information is important to us. That's why we implement rigorous security measures to make sure your online information remains private and secure.

3. PLAN INFORMATION

If you have out-of-state employees, the maximum subscribership can't exceed 30% of the overall group enrollment. Example: A group of 10 subscribers can't have more than 3 out-of-state employees on a PPO plan.

- A group can't offer more than one PPO plan.
- KPIC (PPO) plans can be sold alongside any Kaiser Foundation Health Plan, Inc. (KFHP), products (HMO, DHMO w/HRA, HSA-qualified HDHP).
- 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 deciding if participating provider physicians and facilities meet their needs. Employees can search for available providers and facilities at **multiplan.com/kaiser**.

Note

Grandfathered plans are also known as "nonmetal" plans.

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

Here's an overview of your options. If you have any questions, please call **800-790-4661, option 3** to speak with our Small Business Services, Account Management Support Team, or contact your broker.

Grandfathered (nonmetal)

- If your plan has covered at least one employee without lapse in coverage and continued unchanged since the ACA was signed into law on March 23, 2010, it's considered a grandfathered (nonmetal) plan.
- 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.
    - o This means you can continue offering your employees the same plan at your renewal.
- You also have the option of moving from a grandfathered (nonmetal) plan to one of our ACA-compliant metal plans.
    - o If you choose to move to one of our metal plans, you can purchase Kaiser Permanente coverage through us, your broker, Covered California for Small Business, or through California*Choice*®. You can learn more at **coveredca.com/forsmallbusiness**. For information on California*Choice*, visit **calchoice.com**.
    - o Please note that if you choose to move to one of our metal plans, you won't be able to go back to your current grandfathered (nonmetal) plan after you leave it.

Essential health benefits

For 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†

Note

For more information on child dental, go to **kp.org/smallbusinessplans/ca**.

*Excludes grandfathered (nonmetal) plans.
†Pediatric vision embedded in the medical plan.

Plan information

The copay HMO plans, HSA-qualified deductible HMO plans, deductible HMO plans, and the deductible HMO plans with HRA are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plans, as well as the Premier and PPO dental plans. The chiropractic/acupuncture plan is administered by American Specialty Health Plans of California, Inc.

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

Metal plans

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

Deductible HMO plans – A deductible is the set amount you must pay for most covered services within a plan year before your health plan begins to pay. After you reach your deductible, you'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 you reach your out-of-pocket maximum. Depending on your plan, you may pay copays or coinsurance for some services without having to reach your 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, 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**.

*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 you'll set up for your employees. You contribute money into your 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.*

*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 – These plans give you referral-free access to participating physicians or any other licensed provider of choice. KPIC (PPO) plans can be sold alongside any Kaiser Foundation Health Plan, Inc. (KFHP), products (HMO, DHMO w/HRA, HSA-qualified HDHP).

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

Child dental

- All metal HMO and PPO plans cover the ACA-defined essential health benefits, which includes child dental services.
- HMO members are enrolled in a separate child dental benefit underwritten by Delta Dental of California.
- PPO medical plan members receive child dental PPO 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.

Chiropractic/acupuncture

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

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

Note

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

Supplemental Family dental plans (optional)

- Family dental plans can only be purchased when you first enroll or at renewal.
- Family dental plans are available only 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 you offer dependent coverage). However, they're not a substitute for the child dental coverage required by ACA regulations for members under 19 years old.

For Delta Dental of California benefits and rates, and for information on the DeltaCare HMO plans, call our Small Business Services, Account Management Support Team at **800-790-4661, option 3** or email us at amt@kp.org.

For a list of providers, visit the Delta Dental website.

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 aren't available with our HSA plans. If you choose 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.
- You can discontinue your current chiropractic/acupuncture coverage anytime up to 4 months before your renewal date, or at renewal.
- You can add a new chiropractic/acupuncture plan only at renewal.

For a list of providers, visit the American Specialty Health website.

For more information, call **800-790-4661, option 3.**

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.
- You can only add or discontinue this benefit upon renewal, if it isn't selected as part of the original contract.

4. GROUP AGREEMENT/EVIDENCE OF COVERAGE (EOC)

Group Agreement/contract delivery

Each year when you renew, we'll deliver your new contract *(Group Agreement)* online through our online account services, unless you selected "mail" as your delivery preference on your Employer Application. Your new contract will be online up to 60 days from renewal.

Viewing your contract online

If you haven't already done so, we encourage you to register for online access. This is the easiest and fastest way for you to view or download a copy of your contract. You can also request a copy by calling the Small Business Services, Client Services Unit at **800-790-4661, option 2** or emailing csu.ca@kp.org.

If you have questions about your plan benefits, please see your *Evidence of Coverage*.

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 your employees residing in both Northern and Southern California, then separate regional contracts may be issued based on the following rules:

- Your location is typically considered the home region.
- When 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).

Evidence of Coverage (EOC)

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

Summary of Benefits and Coverage (SBC)

In accordance with the ACA, we provide downloadable versions of the Summary of Benefits and Coverage (SBC) documents for each of our plans on **kp.org/smallbusiness-sbc/ca**. These documents, based on the Department of Health and Human Services' required format, summarize important information about each health plan option, so you can easily compare Kaiser Permanente benefits and coverage with those of other carriers. For additional information, please contact the California Service Unit at **800-790-4661, option 2.**

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.

Note

If you provide SBCs electronically, you must comply with the SBC regulations. For more information, visit **dol.gov/ebsa/healthreform**

The scenarios and time frames for providing SBCs are listed below:

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

For additional information, including the *Glossary of Medical and Health Coverage Terms* and the SBC guide for fully insured employer plans, visit **kp.org/smallbusiness-sbc/ca**.

5. EMPLOYER OBLIGATIONS

Administrative requirements for employers

As the employer and administrator of Kaiser Permanente health benefits, it's important for you to know your responsibilities and obligations. Keep in mind that while brokers can provide you with valuable support in completing certain administrative tasks, you're ultimately accountable.

Listed below are the administrative tasks you're responsible for. Click on each task for more detailed information.

1. Supplying copies of *Evidence of Coverage (EOC)*
2. Supplying copies of Summary of Benefits and Coverage (SBC)
3. Notification of enrollment
4. Notification of leaves of absence
5. Notification of member termination
6. Administering COBRA coverage
7. Indicating ERISA status

Health care reform (HCR) represents significant changes in the U.S. health care system. For help navigating through these changes, and to find out how your business may be affected, please see the section on plan information, or visit **account.kp.org** for a downloadable HCR resource guide. Kaiser Permanente recommends that employers consult their own legal counsel, tax advisor, and financial experts for advice related to plan administration, ERISA, and the ACA.

6. 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 may lead to quicker dispute resolutions.

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

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

If you collect enrollments 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 arbitration team, your enrollment process is in compliance. We recertify universal forms on an annual basis; please email your form to: **CA-Arbitration@kp.org** and if you have any questions please contact our Small Business Services, California Service Center at **800-731-4661, option 1.**

If you collect enrollments using an online enrollment website: We have developed a web service tool that makes it easier to display our binding arbitration notice and capture agreement to arbitration signatures at the point of enrollment. This tool, called the California Arbitration Management System (CAMS), is a web service that can be added to an enrollment website. If you use an online enrollment site, please contact our Small Business Services, Client Service Unit at **800-731-4661, option 2.**

Regulations

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

1363.1. Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:

1. The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.
2. The disclosure shall appear as a separate article in the agreement issued to the employer group or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.
3. The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.
4. In any contract or enrollment agreement for a health care service plan, the disclosure required by this section shall be displayed immediately before the signature line provided for the representative of the group contracting with a health care service plan and immediately before the signature line provided for the individual enrolling in the health care service plan.

1. ELIGIBILITY

Eligibility requirements

Your company may be eligible for Kaiser Permanente's guaranteed issue and guaranteed renewable small group health plans if you 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. They include:

- You must offer health plan coverage to 100% of your eligible employees. Carve-outs are not permitted.
- You must have at least one but no more than 100 full-time and full-time-equivalent (FTE) employees for at least 50% of your business's working days for the previous calendar quarter or previous calendar year.
  - o 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. They must have a normal workweek averaging 30 hours per week over the course of a month, work at your regular place of business, be subject to withholding on a W-2 form, and have met their waiting period, if applicable.
  - o 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.
- You must have at least one W-2 employee (not including sole proprietor owners, partners, their spouses or legal domestic partners) enrolling in Kaiser Permanente or another group health coverage plan and ensure that you comply with the health plan's participation requirements.
- If you're an enrolling proprietor, partner, or corporate officer who isn't listed in the DE 9C, you need to complete and submit an Owner/Officer Eligibility Statement and other applicable documents.
- 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. In determining group size, affiliated companies eligible to file a combined tax return for purposes of state taxation are considered one employer even if you're not presently filing together.
- You 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.

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.

Note

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

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

For more information about recertification, including documentation required, go to: **kp.org/smallbusiness-recertification/ca** or call **877-490-4983.**

Ineligibility

Your business or some of your employees may be ineligible under certain circumstances. The following employer classifications don't meet California small business legal requirements 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 doesn't make it eligible by default.

- *Retirees* — Former employees who may be eligible for retiree benefits if offered by the employer after meeting age and other requirements.
- *Contractors (1099)* — Those 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.

Minimum age

All subscribers, with the exception of an emancipated minor (documentation is required for emancipated minors), must be 18 years old as of the customer's contract effective date. **Small Business won't enroll an employee under 18 as a subscriber, unless he or she is an emancipated minor.**

Waiting period

If you establish a waiting period, the following criteria must be met:

- It's your responsibility to ensure that you don't apply a waiting period of more than 90 days (in accordance with the ACA).
- You 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 your responsibility to administer and track these requirements.
- The effective date of coverage for new employees and their eligible family dependents is always on the first of the month and it can't exceed the maximum 90-day waiting period.

Kaiser Permanente will rely on the eligibility information reported by the employer and assume that the employer is in compliance.

How to enroll new hires

1. Have each new enrollee complete and sign an Employee Enrollment form. Be sure the form is completed. Missing or inaccurate information will delay enrollment processing. Keep copies of all completed and signed enrollment forms and any other proof of enrollment you receive. Members transferring from another Kaiser Permanente Health Plan (within the same region), keep their existing membership card, as their medical record number remains unchanged.

2. Submit the new enrollee information to Kaiser Permanente:

- **Through online account services**
  If you don't receive confirmation of new online enrollment within a few days, call the enrollment department at the Small Business Services, California Service Center **800-790-4661, option 1** or check your online account services account.

- **By fax or email**
  Fax completed forms: **855-355-5334** or email **csc-sd-sba@kp.org**.

Enrollment applications should be submitted 2 to 3 weeks before the effective date to ensure that we'll have enough time to process the applications and mail the member ID cards.

To verify receipt of enrollment forms, call **800-790-4661, option 1** 72 hours after you send the forms. Most forms are processed within 7 to 10 days of receipt.

Enrolling eligible dependents

Note: This section applies only if you offer dependent coverage.

Dependents must be enrolled with the subscriber during the initial enrollment. Dependents not enrolled can only be added midyear if there's a qualifying event.

New enrollees who also wish to enroll their dependents can do so by completing the "Family Information" section of the Employee Enrollment form. Dependents can't choose a different plan than that of the subscriber. Dependents must enroll during open enrollment, unless they experience certain qualifying events.

Enrollment provisions

New dependents must be added within 60 days of becoming eligible if the addition is because of any of the following qualifying events:

- Marriage/acquisition of domestic partner
- New birth
- Adoption or placement for adoption
- Involuntary loss of other coverage
- Dependent moved into the service area
- Qualified medical child support order (QMCSO)

Adding Dependents

Employees who want to add a dependent should complete the Employee/Dependent Change form. You can submit the enrollment through online account services, or fax the completed form to **855-355-5334.** The enrollment must be submitted within 60 days of the qualifying event.

We don't require documentation of domestic partnership in order to enroll a domestic partner as a dependent.

We also don't require documentation for the addition of a dependent who's a newborn or newly adopted.

A copy of the court documents is required to add a dependent as a result of a qualified medical child support order.

Coverage effective dates

- A newborn child is covered at birth; however, the child must be enrolled within 60 days of birth for coverage to continue past the first month.
- Coverage of a newly adopted child begins on the date the adopting parent gains the legal right to control the child's health care. However, the child must be enrolled within 60 days of that date for coverage to continue.
- Coverage for other dependents begins on the first day of the month following the date of the qualifying event. They must be enrolled within 60 days of the qualifying event.
- Coverage for dependents due to court order starts the first of the month following the court order date.
    - o The subscriber must be enrolled in order to enroll dependent(s).
    - o The subscriber must have met the waiting period set in place in order to enroll.
    - o All required court order documents must be provided in order to enroll dependent(s).
    - o The subscriber can change to a plan option currently available midyear in order to afford the enrollment of the dependent.

Disabled overage dependent children

Dependent children can stay on a group plan until they reach age 26. Disabled dependents can remain on the plan beyond age 26 as long as they meet the eligibility requirements for disabled dependents. Contact the Member Service Contact Center at **800-464-4000** for assistance.

Declination documentation

Each eligible employee who declines group health coverage must complete the *Waiver of Coverage* form.

Open enrollment

Open enrollment is an annual event that occurs the month before your renewal.

During open enrollment:

- You must offer health coverage to anyone who declined coverage when they became eligible.
- Subscribers can also add dependents not previously enrolled.
- If you offer multiple plan options, current subscribers can change from one plan to another.

Enrolling previously ineligible employees

When an ineligible employee becomes eligible (for example, if a part-time employee becomes full time), follow these guidelines:

- You can enroll the employee on the first of the month following the event date as long as the employer-imposed waiting period has been met. Or you can choose to impose a waiting period from the date the employee becomes full time.
- In either case, submit an enrollment application for each employee who has become eligible and indicate the effective date of coverage.

Qualifying events

There are circumstances in which employees other than new hires become newly eligible for coverage. These circumstances are called *qualifying events*. The same qualifying events must apply to all the health plans that you offer. Qualifying events include:

- Increase in hours so that he or she meets your requirement for medical plan eligibility
- Return from a leave of absence
- Involuntary termination or loss of other group coverage
- A dependent loses coverage elsewhere
- Marriage or addition of a domestic partner
- Birth
- Adoption of a child or placement for adoption
- Court order
- Death of a spouse, domestic partner, or dependent

Leave of absence/military leave/medical leave

A return from a medical leave, military leave, workers' compensation, or other leave of absence is considered a qualifying event. There's no waiting period if the employee returns to active employment and works the minimum required hours per week.

Termination requests

A request for termination must be received by Kaiser Permanente within the month of termination.

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

Re-enrolling employees

Coverage for a rehire is effective on the first of the month following the date of rehire, for example: if the rehire date is within one year of the original termination date. If the rehire date is more than one year after termination, the employee will be considered a new hire and must satisfy the new-hire waiting period, as described in your *Group Agreement*, before being enrolled.

If you choose to impose the waiting period, submit the Employee Enrollment form as a "new hire" indicating the requested effective date of coverage on the form.

2. CHANGING ENROLLMENT COVERAGE

Reporting membership changes

Policies for when groups can report membership changes:

- All membership terminations will be effective **in the month the request to terminate is received,** unless the group requests that the termination be effective in a future month. We won't retroactively terminate subscribers and/or dependents prior to the month we receive the request to terminate.
- Subscribers and/or dependents can be added retroactively up to 2 months prior to the month the request is received. Standard enrollment rules apply (new-hire eligibility and qualifying event date for dependent(s): newborn, marriage, etc.).

Updating enrollment information

To update enrollment information — such as name, address, or phone number — have the employee complete the Employee/Dependent Change form. You can submit the changes through online account services, fax the completed form to **855-355-5334** or email the changes to csc-sd-sba@kp.org.

Terminating membership

You're required to report a termination for anyone who becomes ineligible for coverage.

To terminate membership coverage, complete the Subscriber, Termination, Transfer and Reinstatement form. You can submit the changes through online account services or you can fax the completed form to **855-355-5334** or email the completed form to csc-sd-sba@kp.org.

When an employee's coverage is terminated, the entire family account is terminated, including coverage for any dependents. Depending on the reason for termination, the employee and dependents may be eligible for other health coverage, such as:

- Individual or conversion plans
- COBRA continuation coverage
- Cal-COBRA continuation coverage

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

For additional information on COBRA, click here.

Terminating dependent coverage

Overage dependents

Dependent coverage is offered up to age 26 (we won't terminate a dependent mid-month, rather coverage is extended through the end of the month). Before a dependent turns 26 years old and no longer qualifies for coverage through a parent, we'll notify the group that the dependent is being terminated from group coverage. See your group agreement for additional details.

Divorce/legal separation/termination of domestic partnership

If an employee divorces, legally separates, or terminates a domestic partnership, the spouse or domestic partner no longer qualifies for coverage. To terminate the dependent's coverage, have the employee complete the Employee/Dependent Change form. You can enter the information and submit the change through online account services, fax the completed form to **855-355-5334** or email the completed form to csc-sd-sba@kp.org.

Voluntary termination by employee

If an employee chooses not to continue with Kaiser Permanente, complete the Subscriber, Termination, Transfer and Reinstatement form. You can submit the changes through online account services, fax the completed form to **855-355-5334** or email the completed form to csc-sd-sba@kp.org.

Certificates of creditable coverage

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

Certificates are mailed to the member's home address shortly after the termination date.

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

3. GROUP COVERAGE CHANGES

Annual renewals

Renewal is easy. Approximately 60 days before your annual renewal date, we'll send you a notification e-mail that your annual renewal is available online at **account.kp.org** to view any rate or plan changes. Included in your online renewal kit will be a snapshot of your business's health plan(s) and enrollment based on information in our systems.

You can make changes anytime in those 60 days before your effective date. However, these changes will take effect on your renewal date. The sooner you return your renewal changes, the sooner we can get your new information into our system and reflect your changes on your billing statements.

Note

Download the forms you use most, including enrollment forms, at **kp.org/smallbusinessforms/ca**.

How to view renewal options and make changes

You're automatically defaulted to receive your annual renewal electronically at **account.kp.org**; your one-stop shop to manage renewals online, access your renewal kit, shop, and make plan changes the moment they're available.

Get more done in less time

- View group renewals and make plan changes instantly on-line without waiting 1-2 weeks for mail to arrive.
- Explore different renewal options and make changes online without having to fill out and mail forms.
- Check out plans, rates and benefits, and compare your options.
- Change plans, add new enrollees, and make changes to existing employees instantly.
- Access your full transaction history in one place.

Register or sign in at **account.kp.org** to get started today.

Questions?

Contact your broker or email our Small Business Account Management Support Team at **amt@kp.org** and include your group name and ID.

Click here to view renewal options and videos.

How we determine your renewal rates

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. We then adjust the plan rates according to rating factors applicable to the plan type — grandfathered (nonmetal) or metal. Final rates are based on actual group enrollment. Rates are guaranteed for 12 months and are valid only from the effective date stated in the group contract.

The rate calculation for ACA-compliant metal plans is different from the rate calculation for 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:
  - o If your business is located inside California, rates are based on the physical address (ZIP code +4 and county) of your business. This is referred to as the Live/Work rule.
  - o Businesses located outside California are assigned to rating area 4.
  - o A post office box or other purchased address can't be used as a business address. If we discover that you're using an address other than your business's physical location, we may rescind or terminate your coverage.
- Member age:
  - o 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.

Note

For current rate information, call our Small Business Services, Client Services Unit at **800-790-4661, option 2.**

- If a family has more than 3 children under 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.

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 your business is located in a California service area, rates are based on the physical address (ZIP code) of your business.
  - If your 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 a business address. If we discover that you're using an address other than your business's physical location, we may rescind or terminate your 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 small business 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.

Note

Annual renewals are available online. If you wish to receive paper renewals via mail, you'll need to opt out by logging onto **account.kp.org**.

How to renew your coverage

No changes to coverage

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

Renewal Plan changes

Please refer to your Small Business Renewal Information (available 60 days prior to your renewal).

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

Be aware that if you have a grandfathered (nonmetal) plan and move to a metal plan, you won't be able to go back to our grandfathered (nonmetal) coverage.

- You can only make a plan change if your account is current.
- You 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 5 p.m. (PT) on the 15th of the renewal month can be applied retroactively to the first of the month.
  - o A plan change request received after 5 p.m. (PT) the 15th of the effective month is effective the first of the following month.
  - o Deductible accumulation amounts may not be transferable.

Covered California for Small Business

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

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

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

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

Nonrenewal (Midyear plan changes)

A plan change made outside of the renewal is considered a midyear plan change. With certain rules and restrictions, you can add additional plans, discontinue a plan (if you have more than one), or downgrade your current plan up to 120 days before your renewal effective date.

Note

This document is designed to provide a general overview of portions of the ACA and shouldn't be relied upon as legal or tax advice. Federal and state laws and regulations are subject to change. Seek professional advice from an independent tax adviser or legal counsel regarding how the requirements will affect your particular circumstances. Information may have changed since publication.

To request a plan change, complete the Plan Add/Change Request form and fax it to **800-369-8010.** Changes submitted by 5 p.m. (PT) between the 1st and 15th of the month will be effective the first of the same month, if requested. Changes submitted between the 16th and the last business day of the month will be effective the first of the following month.

Changes submitted between the 1st and 15th, or the last business day of the month must be received at Kaiser Permanente Small Business by fax **(800-369-8010)** by 5 p.m. Requests not received by 5 p.m. will be considered to be received the following business day. If the 15th or the last day of the month falls on a Saturday or Sunday, the fax is due the next business day.

It may take up to 2 billing cycles for plan changes to be reflected on your bill.

Multiple plan option (MPO)
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 1 PPO plan.

PPO plan
You can offer a PPO plan when you meet all the following requirements:

- You can't offer more than one PPO plan.
- You must offer the PPO plan to all eligible employees.
- Kaiser Permanente must be the sole carrier for all medical coverage.

If you have out-of-state employees, the maximum subscribership can't exceed 30% of the overall group enrollment.

Example: A group of 10 subscribers can't have more than 3 out-of-state employees on a PPO plan.

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.
- HSA-qualified HDHP HMO.

Note

If you're making a plan change, please review the crossover scenarios found on page 24 of this document.

For more information

For more information and to get more plan change scenarios, please contact your Kaiser Permanente sales executive or account manager.

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's group ID changes –** for example, a business consolidates or is acquired, or it transfers to or from California*Choice* 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.

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

Notes

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

[2]"HSA-qualified" 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.**

4. GROUP CHANGES

Address change

To change your mailing address, business address, business name, or business contact, complete the Customer Address or Name Change Request form and fax it to **800-369-8010.**

Contact information change

To change your billing contact or contract signer, and for interested party changes, complete the Contact Change Request form and fax it to **800-369-8010.**

Change of ownership

For change of ownership, please contact our Small Business Services, your account manager, or Account Management Support Team at **800-790-4661, option 3,** or email amt@kp.org, and a representative will be happy to walk you through the process and paperwork.

Broker change

If you change brokers, fax a signed (no stamped or computer-generated signature) letter on business letterhead to **800-369-8010** advising us of the change of broker. Please include your group ID; the name, address, and phone number of the new broker; the broker ID number; and the agent of record. The letter must be signed by the authorized signer currently on file at Kaiser Permanente.

5. TERMINATING GROUP COVERAGE

Voluntary termination

You can terminate your group coverage for any reason with 15 days advance notice as required by your *Group Agreement*. A voluntary termination can't override an administrative termination.

Contracts are terminated on the last day of the month.

Requesting termination
To request termination, contact the Account Management Support Team at **800-790-4661, option 3.**

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

- The customer will keep its prior group ID.
- The customer's renewal date is the same date the customer had prior to the termination.
- The customer retains their grandfathered (nonmetal) status.
- The customer is responsible for premiums retroactive to the termination date.

All reinstatement requests must be approved by a manager, submitted on business letterhead, and faxed to Kaiser Permanente Small Business at **800-369-8010.**

Administrative termination

We can terminate your coverage for any of the following reasons:

- Failure to provide accurate eligibility information or other breaches of contract
- Group and members aren't in the service area
- Fraud or intentionally furnishing incorrect or incomplete information
- Nonpayment of premium

- Failure to meet minimum contribution, participation, or other requirement
- Failure to provide appropriate documentation upon request
- Failure to complete the recertification process satisfactorily
- Zero enrolled members in the contract

Contracts are terminated on the last day of the month.

6. 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 ID 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.

Common ownership

If you've obtained a new business name and/or tax ID number, or if you're a former group customer, the same re-enrollment rules will apply to a group with common ownership. Common ownership groups may include but aren't limited to: like ownership, like business, and may or may not include like membership or demographics.

Termination by recertification

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

Coverage options following termination of coverage

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

Extension of benefits for total disability

If your contract is terminated, medical coverage continues for 12 months premium-free for a disabled employee or disabled dependent. However, coverage will be terminated earlier if:

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

Disability certification must be approved before we'll extend health coverage.

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

Which COBRA plan applies to you?

- Federal COBRA is for groups with 20 or more employees.
- State (or Cal-COBRA) is for groups with 2 to 19 employees.

1. COMPARISON OF COBRA AND CAL-COBRA

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

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

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

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

For information on Cal-COBRA, please call the Member Service Contact Center at **800-464-4000.**

2. FEDERAL

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

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

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

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

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

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

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

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

Kaiser Permanente–billed federal COBRA activity report
Kaiser Permanente will mail you this report each month to notify you of the membership status of your federal COBRA members for whom Kaiser Permanente does the billing and collecting. This report will be generated monthly and should be received by the end of each month. The report will provide the COBRA member's name, Social Security number, address, family role, and the start and expected end date for COBRA coverage.

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

How to enroll COBRA members

When an employee or dependent chooses Kaiser Permanente COBRA coverage, he or she submits the completed Kaiser Permanente COBRA enrollment form directly to the group. You'll then submit the enrollment form and report any terminations the same way you usually report membership changes. We won't accept any COBRA enrollment forms directly from your employees.

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

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

Employee notification

It's always the employer's responsibility to notify employees about federal COBRA, including any information regarding new rates or benefit changes. Members who call Kaiser Permanente for COBRA enrollment information will be referred back to their employers.

Termination of employer contract

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

Open enrollment changes

If you have COBRA participants who elect to change from a different carrier to Kaiser Permanente during an open enrollment period, you must notify Kaiser Permanente of the original COBRA start date(s) of the participant(s).

3. ERISA STATUS

On July 23, 2010, the Departments of Labor, 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 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 NGA and then annually with the renewal notice to update Kaiser Permanente if the reported status is no longer valid.

The 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**) has information that'll 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's recommended that he or she consult a financial or legal adviser.

4. FEDERAL TEFRA

- **The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** is a federal law that established Medicare Secondary Payer (MSP) rules. When MSP applies, Medicare isn't responsible for paying primary for a member's covered health care services when the member is age 65 or older and covered by a group health plan. An employer's group health plan MSP status is determined based on a yes or no response to the following question:

  Did a company employ 20 or more full-time and/or part-time employees for each workday for 20 or more calendar weeks in the current calendar year or preceding calendar year, making its group health plan subject to MSP?

  - If yes to the question, then the employer's group health plan is subject to MSP and will pay primary to Medicare.
  - If no to the question, then the employer's group health plan isn't subject to MSP and Medicare has primary payment responsibility.

- Regardless whether Medicare is primary or secondary, the following information applies to employees who are 65 years old, Medicare eligible, and enrolled in a group health plan (Medicare defines as "Working Aged"):

- Kaiser Permanente doesn't require employees who are Working Aged to enroll in Medicare Parts A or B. Member copay and coinsurance will be the same as any other employee enrolled in that group's coverage. Penalties for enrolling late in Medicare Part B are waived while the individual is enrolled in qualifying group coverage.
- There's no balance billing per the normal terms in the Evidence of Coverage (EOC).
- If 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.
- 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.

- When a member is on both KPSA and a group plan, and the group's health plan is subject to Medicare Secondary Payer (MSP), then the member is enrolled on a special MSP plan for integrated coordination of benefits (COB). This same situation doesn't apply when the group coverage is considered the secondary payor to Medicare. A member still receives through COB a $0 deductible and $0 copay/coinsurance including prescription drugs.
- 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.

5. STATE COBRA

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 wasn't in business during any part of the preceding calendar year if the employer employed 2 to 19 employees for at least 50% of the working days in the preceding calendar quarter.

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

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

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

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

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

Billing and payment

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

6. SMALL EMPLOYER CUSTOMER NOTIFICATION

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

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

Member notification for those enrolled in federal COBRA

Kaiser Permanente will notify members who have exhausted their COBRA coverage (if they're entitled to fewer than 36 months of federal COBRA) of their opportunity to enroll in Cal-COBRA and extend the term of their continuation coverage to 36 months. The notice is included with other options that may be available.

If your employees have any questions about Cal-COBRA, they should call the Member Service Contact Center at **800-464-4000.**

1. KAISER ON-THE-JOB®

Overview

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

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

How to become a part of Kaiser On-the-Job

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

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

For more information

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

2. KAISER PERMANENTE WORKFORCE HEALTH

Overview

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

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

Let's get started

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

- **The Total Health Assessment** gives employees a personalized action plan that directs them to one or more healthy lifestyle programs to help them achieve their goals.

- **Educational tools,** including health and drug encyclopedias, calculators, and a symptom checker, give employees a clearer picture of their health.
- **Healthy lifestyle programs** coach employees on how to manage conditions such as back pain, depression, diabetes, and insomnia.
- **Online health videos** highlight a wealth of important health topics to keep employees informed and engaged on their wellness journey romon**.**
- **The Total Health Radio** online radio show and podcast offer employees health tips, advice, and guided-imagery audio programs.

3. MEMBER SERVICES

Members can call our Member Service Contact Center for answers to questions about:

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

Phone numbers and hours of operation

Member Service Contact Center
Open 24 hours a day, 7 days a week. Closed holidays.
800-464-4000

711 (TTY)

800-788-0616 (Spanish)

800-757-7585 (Chinese dialects)

Claims

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

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

Tip

Your employees who are enrolled in Kaiser Permanente plans can take advantage of even more tools and resources, like online programs to help them quit smoking, design custom health and fitness plans, or manage ongoing conditions, such as asthma and diabetes. You may benefit from setting up a general-use computer for employees who don't usually have computer access at work.

Notes

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

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person would have believed that the absence of immediate medical attention would result in any of the following: (1) placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above or, for members who aren't enrolled in Kaiser Permanente Senior Advantage, when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true: the person is an immediate danger to himself or herself or to others, or the person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder.

Help in your language
Interpreter services, including sign language, are available during all hours of operation at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call our Member Service Contact Center 24 hours a day, seven days a week (except closed holidays) at **1-800-464-4000** (TTY users, call **711**).

Ayuda en su idioma
Se ofrecen servicios de intérprete sin costo alguno para usted durante todo el horario de atención, incluida la lengua de señas (sign language). También podemos ofrecerles a usted y a sus familiares y amigos todo tipo de ayuda especial que necesiten para tener acceso a nuestros centros y servicios. Además, puede solicitar que los materiales del plan de salud se traduzcan a su idioma, y que estos materiales sean con letra grande o en otros formatos que se acomoden a sus necesidades. Para obtener más información llame a la Central de Llamadas de Servicio a los Miembros las 24 horas del día, los siete días de la semana (excepto los días festivos) al **1-800-788-0616** (usuarios de TTY llamen al **711**).

以您的語言提供協助
我們在辦公時間內免費為您提供口譯服務，包括手語在內。我們也可以向您本人、您的家人和朋友提供使用我們設施和服務时所需的任何特別協助。此外，您可以要求將會員資料翻譯成您的語言，並且要求這些資料以大字版或其他格式來滿足您的需求。如需更多資訊，請致電我們的會員服務電話中心，我們每週 7 天，每天 24 小時為您服務（節假日休息），電話號碼是 **1-800-757-7585**（免費電話）（TTY 使用者請撥 **711**）。

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

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

American Specialty Health Plans of California, Inc.
The administrator of the chiropractic/acupuncture coverage for our HMO plans.

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

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

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

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

Cal-COBRA (California Continuation Benefits Replacement Act)
California continuation coverage that allows continued access to California group health coverage.

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

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

contract

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

2. An agreement that defines the terms and conditions set by Kaiser Foundation Health Plan, Inc., and the employer, which are documented in the *Group Agreement*.

contract freeze

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

conversion

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

coordination of benefits (COB)

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

copay

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

coverage

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

customer/employer

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

deductible

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

dependent

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

disabled dependent (KFHP plans)

A dependent who exceeds the age limit for dependents but is still eligible for coverage if all of the following requirements are met: The dependent is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition that occurred prior to reaching the age limit for dependents, and receives 50% or more of his or her support and maintenance from the insured.

disabled dependent (KPIC plans)

An overage dependent child who's a child of the insured and is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition that occurred prior to reaching the limiting age, and is 50% or more dependent upon the insured for support and maintenance.

downgrade

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

dues

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

effective date

The date that services provided in the contract begin.

eligibility requirements

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

eligibility rules

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

employer/customer

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

enrollment unit or billing unit

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

event date

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

Examples of event dates include:

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

Evidence of Coverage (EOC)

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

Explanation of Benefits (EOB)

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

grandfathered plan (also known as nonmetal plan)

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

Group Agreement/Contract

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

group ID

The unique ID by which we identify your business.

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

Certificates of creditable coverage issued to terminated members and to active members upon request.

Health Plan

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

Kaiser Permanente Insurance Company (KPIC)
A for-profit subsidiary of Kaiser Foundation Health Plan, Inc., that underwrites our PPO plans, the out-of-network portion of the POS plans, as well as the Delta Dental of California dental plans.

medical record number (MRN)
A unique identification number for a Kaiser Permanente member, typically printed on the member's identification card.

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

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

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

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

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

multiplan.com/kaiser
The website where members can search for a PHCS provider who participates in our PPO plan. (See also PHCS Network.)

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

open enrollment (OE)
The period during which employees and dependents can choose among any health plans offered by their employer.

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

participating provider
Any provider that's part of the KPIC-contracted PHCS network of providers.

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

PHCS
Private Healthcare Systems

PHCS Network
The national physician network with which we've contracted to provide services to our POS and PPO plan members. PHCS Network is part of the MultiPlan family of provider networks. (See also **multiplan.com/kaiser**.)

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

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

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

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

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

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

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

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

service area

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

small business

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

subscriber

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

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

Summary of Accumulation (SOA)

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

Summary of Benefits and Coverage (SBC)

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

termination

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

waiting period

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

workers' compensation

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