Underwriting Guidelines

Kaiser Foundation Health Plan, Inc.
Kaiser Permanente Insurance Company

For businesses with 1 to 100 employees
Effective January 1, 2025

NEW GROUP ENROLLMENT CHECKLIST

Once plans have been selected, refer to this enrollment checklist to keep track of everything for a smooth submission process.

Enrollment is as easy as 1, 2, 3. Visit **business.kp.org** to download the most current form to avoid processing delays, and type or print neatly using black ink, ensuring the completion of all fields on each form.

Brokers: Email group submission (items 1–3) to **KPSBUBrokerNewGroups@kp.org**. For assistance, call **800-789-4661.**

☐ 1. Employer Application – Completed and signed by authorized company signer.

☐ 2. Employee Enrollment – Completed and signed by each eligible employee/owner applying for coverage. Employees keep a copy for their records. Alternative form: Census form completed by the employer or company representative.

☐ 3. Initial payment – The Electronic Transfer for Payment form is for the first month's payment with the option to set up recurring autopay (recommended). Complete the form, and do not include a blank or voided check. Processing of the initial payment is within 5–7 business days of contract activation. We do not accept credit card payments.

Employers must **complete and keep** the Declination of Coverage form listing all eligible and declining employees for their records. **Kaiser Permanente reserves the right to ask for additional documentation.** Refer to Section 8, Business and Proof of Ownership Documentation, for additional details.

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SECTION 1 – Introduction

These are Kaiser Permanente guidelines used to evaluate and offer coverage to small business employer accounts. These guidelines aren't intended to be all-inclusive and are subject to change without notice as permitted under the law. *Other policies and guidelines may apply; see* Kaiser Permanente policies (kp.org).

The specific terms of coverage or requests for changes and the final decision to accept or decline a group for coverage are contingent upon applicable authorization from Kaiser Permanente, and subject to applicable law.

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

SECTION 2 – Eligibility

To qualify for Kaiser Permanente's guaranteed issue and guaranteed renewable small business health plans, an employer must continuously meet certain requirements, as defined by the ACA, the California Small Group Reform Act, and Kaiser Permanente's small group eligibility requirements.

EMPLOYER ELIGIBILITY

- An employer must have at least one W-2 employee (not including the sole proprietor, owner, partners, their spouse, or legal domestic partner) but no more than 100 full-time and full-time-equivalent employees for at least 50% of its working days for the previous calendar quarter or year. See *Employee Eligibility* below for more information. **For Corporations and LLCs only:** A corporate officer who is a W-2/common-law employee is considered an eligible employee. The officers can be spouses, domestic partners, or unrelated.
- Affiliated companies that are eligible to file a combined tax return for the purposes of state taxation, will be considered one employer (even if they are not presently filing together) to determine group size but may choose to apply for coverage separately.
- California and out-of-state based employers with employees hired in California must have a California workers' compensation policy or an employer's liability benefit available as required by law.
- An employer must maintain business licensure and/or appropriate state filings allowing the business to conduct business in California.
- If an employer's business is located outside the California Kaiser Permanente service area or out-of-state, only employees living in Kaiser Permanente's service area (per their home ZIP+4 code) are eligible for coverage.
- An employer must offer health plan coverage to 100% of its eligible employees. Carve-outs aren't permitted.
- The business must not have been formed primarily for the purpose of buying a health plan or coverage.

MULTI-MARKET ELIGIBILITY

- Broker must be licensed and appointed in each additional market.
- The multi-market solution is only offered for standard plans and does not apply to exchanges or level-funded plans.
- There is no longer a need to validate via the Secretary of State's website for business licensure or check the employer in multiple markets or "single state validation" because these are extensions of the first group. (**Exception:** In Hawaii, a Department of Labor [DOL] number is required.)
- Small group size is defined by state law, and any market with enrollment must adhere to it.
- Group size is determined by pooling all FTEs/employees across all markets.
- California has a threshold of 100 for small groups and requires the majority of employees to reside in their specific market to issue a small group contract.[1]
- Georgia has a threshold of 50 for small groups and requires the majority of employees to reside in their specific market to issue a small group contract.[1]
- All other market groups must have up to 50 employees. (A total group size greater than 50 cannot be issued small group contracts outside of California and Colorado.)
- Each region is rated individually and valid for the entire renewal period.
- Clients will continue to receive a contract and billing invoice from each service area that has a Kaiser Permanente small group plan contract.

SECTION 2 – Eligibility

EMPLOYEE ELIGIBILITY

- A full-time employee is a permanent employee actively engaged in the conduct of business on a full-time basis and must average 30 hours per week over the course of a month, be subject to withholdings on a W-2 form, and have met their group's waiting period, if applicable.
    - A spouse or legal domestic partner of a sole proprietor owner or partner is not eligible without another valid W-2 employee.
- Full-time-equivalent employees are a combination of employees, each of whom individually isn't a full-time employee (because they're not employed on average at least 30 hours per week), but who in combination are counted as the equivalent of a full-time employee.
- For proprietors, partners, or corporate officers to be eligible, they must draw wages, dividends, or other istributions from the business on a regular basis.

Coverage

- Employers are required to offer coverage to employees working an average of 30 hours a week and can choose to offer coverage to employees working at least 20 hours a week if eligibility requirements are met. If coverage is offered to one or more part-time employees, then coverage must be offered to all part-time employees working at least 20 or more hours per week.
- All subscribers must live or work inside the service area applicable to their coverage when they enroll.
- Kaiser Permanente won't cover employees working fewer than 20 hours per week even if local laws require an employer to do so. Contracted or 1099 employees aren't eligible.

Minimum age

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

Minors can be subscribers when:

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

Dependent eligibility

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

- Legal spouse includes same-sex spouses if all California Family Code requirements are met under Section 308(c) for a couple, or Sections 297 or 299.2 for a registered domestic partner.
- Spouse also includes domestic partners who meet the employer group's eligibility requirements for domestic partnerships.
    - Spouses or domestic partners who work for the same employer have the option to enroll as separate subscribers, or one can enroll as a dependent under the other's coverage. An employee can't be both a subscriber under one plan and a dependent under another plan offered by the same employer.

- An employee's or a spouse's children under age 26 (including adopted or placed for adoption children).
- Children under age 26 (not including foster children) for whom the employee or spouse is the court-appointed guardian (or was when the person reached age 18).
- Children under age 26 (not including foster children) whose parent is a dependent under the employee's family coverage (such as, eligible grandchildren of the subscriber), including adopted children or children placed with the employee's dependent for adoption. Additionally, they must:
    - Be unmarried and not have a domestic partner
    - Permanently live with and receive all their support and maintenance from the employee or spouse
- Disabled dependents who meet dependent eligibility rules and satisfy incapacity and financial reliance requirements to be certified as disabled dependents under Kaiser Permanente policy and applicable California legal requirements. The age limit doesn't apply to disabled dependents.

INELIGIBLE CATEGORIES

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

Associations – Groups of nonaffiliated, separate employer entities banded together, unless the group meets the definition of a guaranteed association and has been actively in business since January 1987.

Multiple employer trusts – Employers brought together under a master contract issued to a trustee under a trust agreement for the purpose of providing coverage.

Union trust plans – Union employees under a labor trust fund in which the employer contributes to the fund but doesn't own the master contract.

Owner only (Sole Proprietorship or Partnership) – Groups that don't have a bona fide W-2 employee on payroll.

Taft-Hartley groups – Groups participating in trusts established under the authority of the Labor Management Relations Act of 1948. Group contracts for coverage are issued to the trustees representing one or more unions and/or employers, usually in connection to collective bargaining agreements.

Retirees – Former employees who may be eligible for retiree benefits if offered by the employer after meeting age and other requirements.

Hour bank groups – Taft-Hartley welfare funds where employees meeting specific work-hour requirements can elect to put excess hours into the fund.

Contracted employees (1099) – Employees providing contracted services and who typically receive 1099 forms for income taxes.

Seasonal, temporary, and substitute employees – Employees who aren't hired on a permanent basis or who have a planned termination date.

Other ineligible classifications – Private households, domestic help, members of organizations (such as credit unions and fraternal order members), conservatorships, embassies, and family trusts.

RE-ENROLLMENT AND REINSTATEMENT

Re-enrollment

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

Reinstatement

For groups where Kaiser Permanente coverage is terminated for less than 60 days, the group must request reinstatement of their prior contract to avoid a gap in coverage. This request is conditional provided premiums due are paid in full and the group still qualifies for small group coverage.

SECTION 3 – General guidelines

PARTICIPATION

The employer must ensure that at least one W-2 employee (not including sole proprietor owners or their spouses, partners or their spouses, or legal domestic partners) enrolls in Kaiser Permanente or other group health plan, and comply with the following participation requirements:

- If group has an original effective date prior to January 1, 2025, at least one eligible employee is enrolled under the group agreement.
- If group has an original effective date on or after January 1, 2025, and does not have another carrier, at least one eligible employee is enrolled under the group agreement.
- If group has original effective date on or after January 1, 2025, and has another carrier:
    - If group has less than 20 eligible employees, at least one eligible employee is enrolled under the group agreement.
    - If group has between 20 to 50 eligible employees, at least 3 eligible employees are enrolled under the group agreement.
    - If group has more than 50 eligible employees, at least 5 eligible employees are enrolled under the group agreement.

The employer must ensure that at least 50% of eligible employees are enrolled in a valid health plan. The following are valid health plan waivers if they are covered by:

- Another employer's health plan through a spouse, domestic partner, or parent
- Another health plan offered by this employer or another employer by which they are employed
- Group coverage through COBRA or Cal-COBRA
- Medicare, Medi-Cal, TRICARE (military or VA benefits), or an individual health plan

Kaiser Permanente reserves the right to determine what other types of health plan coverage qualify as valid coverage.

Employees who aren't eligible for coverage, including those who haven't satisfied the employer-imposed waiting period are excluded from the participation percentage calculation. In accordance with applicable laws, the employer determines the waiting period and may waive the waiting period only at the start of a new group contract.

The employer agrees to inform its employees of the availability of coverage, and their refusal of coverage will preclude enrollment until the group's next anniversary or an employee's qualifying event, unless employer meets certain special enrollment guidelines.

WRITING ALONGSIDE OTHER CARRIERS

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

Plan types that don't qualify to be sliced and can't be written alongside our coverage are non-ACA plans, composite rated plans, level-funded or self-funded plans or association health plans (AHPs), including coverage issued for an AHP regulated by the California Department of Insurance. Exceptions: When a slice carrier has out-of-state employees, then composite rated, level-funded or self-funded plans may be permitted.

SECTION 3 – General guidelines

CONTRIBUTIONS BY EMPLOYER

Employers must contribute to all employer-offered health coverage on a basis that doesn't financially discriminate against Kaiser Permanente or against people who choose to enroll in a Kaiser Permanente plan. The contribution can be a percentage or a fixed dollar amount.

- Minimum contribution must be at least 50% of the employee's premium for the lowest-priced Kaiser Permanente medical plan offered by the employer (not including ancillary coverage).
- When Kaiser Permanente is offered alongside another carrier, all contributions for all carriers must be equal.
- Employers aren't required to contribute to dependent coverage.

POLICY EFFECTIVE DATE

Policy effective dates are always the first of the month.

- Final rates are based on actual group enrollment for a specific policy effective date and the actual number of enrollments.
- A change or postponement of a policy's effective date may require a new rate quote.
- Rates may vary by policy effective date.

Existing employees and their dependents (if the employer offers dependent coverage) are eligible for coverage on the employer's effective date.

An employer group can make plan changes up to the 30th day following the group's effective date. A plan change request received:

- By the 15th of the effective month can be applied retroactively to the first of the month
- After the 15th of the effective month is applied to the first of the following month

LATE ENROLLMENT

Completed group eligibility and enrollment documentation received after the first of the requested effective month is considered late. Group submission does not guarantee approval, but rather consideration for the requested effective date.

Note the following potential impacts of a late enrollment:

- The employer is responsible for the full month's premium — no proration or refunds.
- Effective date of coverage will not be changed to a future date.

Potential impacts to the employees:

- The employees and their families will not have member ID cards, nor be active in systems to receive care at medical facilities, until enrollment is complete and processed, which could take 7 to 10 business days beyond complete submission.
- The employees may be billed or asked to pay at point of service.

WAITING PERIODS

The employer may establish a waiting period, in accordance with the ACA criteria.

The employer is responsible to administer and track to ensure their waiting period does not exceed the 90-day maximum waiting period.

Employers can require new employees to complete an orientation period that's no greater than 30 days. Thereafter, the waiting period will begin.

The effective date of coverage for new employees and their eligible dependents is always on the first of the month and can't exceed the maximum 90-day waiting period.

CALIFORNIACHOICE® OR COVERED CALIFORNIA FOR SMALL BUSINESS COVERAGE

Kaiser Permanente doesn't write in slice position but is offered as an option with CaliforniaChoice or Covered California for Small Business (CCSB).

Employer groups moving to CaliforniaChoice or CCSB from Kaiser Permanente, or vice versa, will be issued a new contract and group number. These groups will go through the standard new group and member enrollment processes. Members' medical record numbers will remain the same for members moving within the same region. Member accumulations toward deductibles will be reset to zero at the start of the new contract.

STATEWIDE EMPLOYERS

Kaiser Permanente operates as 2 regions and contracts with employers separately as Kaiser Foundation Health Plan, Inc., Northern California Region and Kaiser Foundation Health Plan, Inc., Southern California Region. Employers with employees enrolled in both regions will be issued 2 separate contracts with unique group ID numbers and rates. The home region will be based on the location of the headquarters or main location. Valid business documentation is required.

- New groups with one or more enrolled subscribers residing in both Northern California and Southern California regions will be issued a separate contract per region.
- When renewing groups with one or more enrolled subscribers residing in the nonhome region, a second contract for the nonhome region will be required at renewal.

EMPLOYERS WITH UNION AND NON-UNION EMPLOYEES

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

The total number of employees must be 1 to 100 full-time and full-time-equivalent employees to be eligible for small group coverage.

Employers who own the union contract and don't pay into the union trust fund must enroll the entire group of union and non-union employees.

When union employees receive health coverage through the union trust fund established by a collective bargaining agreement, then only non-union employees are eligible for Kaiser Permanente small group coverage. The employer is required to submit a current contribution of wages report (itemized), also referred to as a monthly roster.

SECTION 3 – General guidelines

AFFILIATED COMPANIES

Business entities that are affiliated under common control and are eligible to file a combined tax return for purposes of state taxation will be considered one employer to determine group size but may choose to apply for coverage separately (even if filing separately or have a new/separate tax ID number). Section 3A Employer Eligibility of the Employer Application can be used to show affiliation.

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

BREAKAWAY/SPIN-OFF GROUPS

A **breakaway or spin-off** business is a business that is newly formed from employees of an existing business to become a distinct and separate entity. Employees forming this business are no longer employed by the original business and are applying for coverage under a new contract. If they are still eligible to file a joint tax return, irrespective of whether they do, they will be treated as an affiliated company (see above).

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

Grandfathered plans: Nonaffiliated groups that receive a new group number will move to metal plans and only be eligible for grandfathered plans if the new plan mirrors their existing grandfathered plan in all respects required to retain grandfathered status. The original employer in a breakaway/spinoff will remain under its existing contract and be able to keep any grandfathered plan so long as it meets all the legal requirements for retaining grandfathered status.

PROFESSIONAL EMPLOYMENT ORGANIZATIONS (PEOS)

Kaiser Permanente may agree to treat individuals covered by a co-employment agreement with a PEO as eligible employees of a California group for purposes of issuing a contract and enrollment:

A California group must satisfy the small group size requirement (1–100 eligible employees) by combining directly employed and co-employed individuals.

To be considered eligible employees, co-employed individuals may only be enrolled in the group health plan offered by the group, not the group health plan offered by the PEO. The small employer may not allow co-employees to choose between its coverage or the PEO's coverage.

The group must employ the co-employed individuals on a full-time basis and must meet Kaiser Permanente small business underwriting guidelines.

The group may not offer its co-employed individuals both its small group coverage and coverage through the PEO. However, the group may offer Kaiser Permanente small group coverage alongside small group coverage offered by another Issuer that isn't available through the PEO.

TOTAL REPLACEMENT

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

Required documentation

New group documentation, including prior carrier's current bill. Refer to Section 8, Business and Proof of Ownership Documentation, for detailed information.

SECTION 4 – Plan types and policies

AFFORDABLE CARE ACT (ACA) PLANS AND COVERAGE

Metal plans

Metal plans fit into 4 levels of coverage. Each level offers 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. Plans are then categorized by metal tier based on the plan's individual actuarial value.[2]

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

Plans and benefits information is available at https://account.kp.org/business/plans-listing/small-business.

PLAN TYPES

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

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

HSA-qualified high deductible health plan (HDHP)[3] – These deductible HMO plans can be paired with a health savings account (HSA) administered through Kaiser Permanente,[4] giving employees the option to open an HSA. They can contribute pretax or tax-deductible dollars[5] 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.

A monthly $3.25 administrative fee per employee account can be paid by the employer or the employees.

Deductible HMO with HRA plan[3] – This deductible plan is paired with a health reimbursement arrangement (HRA) administered through Kaiser Permanente,[4] which the employer will set up for their employees. The employer contributes money into the employees' HRAs, which they can use to pay for the health care services they receive. This money isn't considered part of their wages, so they won't pay federal income taxes on it.[5]

Groups selecting a deductible HMO with HRA plan must fund this plan for each enrolled employee. The allowable funding range is $200 to $400 per employee and $400 to $800 per family, if the group covers dependents.

Self-employed individuals and their families aren't eligible to enroll in an HRA plan, as stated in IRS Code Section 105(b). Employees of LLC, partnership, sole proprietorship, and S-corporation business types are eligible to enroll in an HRA plan.

A monthly $3.75 administrative fee per employee account is paid by the employer.

PPO

These plans offer referral-free access to contracted physicians or any other licensed provider of choice. PPO plans are underwritten by Kaiser Permanente Insurance Company (KPIC), can be sold alongside any Kaiser Foundation Health Plan, Inc. (KFHP), products (HMO, DHMO, DHMO w/HRA, HSA-qualified HDHP).

- If PPO plans are offered, the minimum group size is one enrolling subscriber, and all eligible employees must be offered the PPO options.
- Kaiser Permanente must be the sole carrier.

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

Employees are responsible for deciding if participating provider physicians and facilities meet their needs. Employees can search for available providers and facilities at kp.org/kpic/ppo.

CHIROPRACTIC/ACUPUNCTURE

Combined coverage for chiropractic/acupuncture care is included on most metal plans; refer to the Plan Highlights. HMO plans – services are administered by American Specialty Health Plans of California, Inc. (ASH Plans). PPO plans – services are administered by Private Healthcare Systems (PHCS).

CHILD DENTAL

All metal HMO and PPO plans cover the ACA-defined essential health benefits, which include child dental services. HMO members are enrolled in a separate child dental plan underwritten by Delta Dental of California. PPO members receive child dental benefits as part of their medical coverage and not as a separate plan.

Child dental services apply to all members under 19 years old. If a child turns 19 before the current contract renews, coverage is extended until the contract renewal date.

SUPPLEMENTAL FAMILY DENTAL PLANS (OPTIONAL)

Supplemental family dental plans can only be purchased by the group at initial enrollment or at renewal. Supplemental family dental plans can be offered with just the richest plan(s) or with all plans.

When a family dental plan is offered, 100% of Kaiser Permanente medical plan subscribers and dependents must enroll. Our supplemental family dental plans cover the entire family, including adults and dependent children up to age 26 (if the employer offers dependent coverage). Our supplemental family dental plans do not substitute for the child dental coverage required by ACA regulations for members under 19 years old.

Additional supplemental 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.

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

FERTILITY BENEFIT – METAL PLANS ONLY

The optional fertility benefit is available for an added cost and only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier.

- Upon selection of this optional benefit, it will be added to all the metal HMO plans offered, as part of the original contract, or can be added or discontinued upon renewal.
- Fertility benefit is already included in all metal PPO plans.

MULTIPLE PLAN OPTIONS

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

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

PPO plan may be offered in Multiple Plan Options and is only available if Kaiser Permanente is the sole carrier.

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

DEDUCTIBLE CREDIT AND CARRYOVER

We don't offer credit for expenses paid by members toward deductibles or out-of-pocket maximums in a medical or dental plan they had with another carrier prior to joining Kaiser Permanente.

All Kaiser Permanente deductibles and out-of-pocket maximum accumulations reset to $0 at the start of the calendar year. Accumulations are not carried over from the previous calendar year to the new calendar year.

Deductible and out-of-pocket maximum accumulations will reset if a group is issued a new group number – for example, if the employer moves their coverage from Kaiser Permanente to CCSB or a private exchange, or from CCSB or a private exchange to Kaiser Permanente and/or reenrollment.

Rates for statewide employers are based on the headquarter location for both Northern California and Southern California contracts. When a group updates their address midyear, their rate changes will only occur at renewal. Proof of headquarter address may be required. (Refer to Section 3, Statewide Employers, for information on when separate contracts are required).

GENERAL RATING INFORMATION

Benefit costs associated with health care delivery for all our small group customers affects our plan rates.

Metal plan rating

Benefit costs associated with health care delivery for all our small group customers affect our plan rates.

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

- Businesses located in California: rates are based on the business's physical address (ZIP+4 and county).
- Businesses located outside of California are assigned to rating area 4.
- A post office box or other purchased mailing address can't be used as the business's physical address location.

Member age

- Each family member has a separate rate based on their age as of the effective date of the group contract. This rate will be used for the full contract year and updated yearly at renewal.
- A family will pay a premium per child for up to 3 of the oldest children under age 21; each additional child after the third will be $0. Note: A premium will apply to every age from 21–26.
- 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[6] include the cost of child dental coverage in the overall rate.

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.

SECTION 6 – Existing accounts

The following underwriting guidelines are specifically for existing employer groups to manage enrolling new employees, recertification, renewal, and making changes to an existing policy.

Metal

Refer to Section 4, Affordable Care Act (ACA) Plans and Coverage.

Grandfathered (nonmetal)

Kaiser Permanente groups may continue to offer their grandfathered (nonmetal) plan if their plan(s) existed and covered at least one employee without any lapse or change in coverage status since the ACA was signed into law on March 23, 2010.

If a group currently offers a grandfathered (nonmetal) plan(s) and eliminates or replaces any of these plan(s) with a metal plan, then their grandfathered (nonmetal) plan(s) and status are lost for that plan(s). Additionally, a grandfathered (nonmetal) plan cannot be replaced by another grandfathered (nonmetal) plan. Some exceptions include a bona fide employment-based reason for the change (other than changing the terms or cost of coverage) or multiple plans remain and currently cover a significant portion of employees.

Metal plan coverage can be purchased directly through Kaiser Permanente, you (the broker), CCSB, coveredca.com/forsmallbusiness, or through CaliforniaChoice, calchoice.com.

Grandfathered (nonmetal) plan rating

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

Rating area:

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

Age band:

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

Family size categories 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):

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

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

GROUP SIZE

An existing group may grow beyond the small business size threshold of 1–100 and remain in small business. It's the group's responsibility to determine its group size, factoring in full-time and full-time-equivalent employees. Refer to Section 7, Guaranteed Availability, for more information. Kaiser Foundation Health Plan, Inc., reserves the right to require receipt of documentation.

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

OPEN ENROLLMENT AND SPECIAL ENROLLMENT PERIOD

Eligible employees and their eligible dependents must initially satisfy the employer-imposed new hire waiting period before they can enroll in their employer-offered health plan coverage. Employers must extend an annual open enrollment opportunity for employees to make any health care coverage changes, including changing plans or adding dependents.

Employees and/or dependents who don't enroll for health care coverage when first eligible nor enroll during their open enrollment period, may not enroll until the next annual open enrollment period.

Special enrollment period is permitted within 60 days of employee's qualifying life event, which includes:

- Increase in hours to meet employer's requirement for medical plan eligibility
- Return from leave of absence
- Involuntary termination or loss of other group coverage
- A dependent loses coverage elsewhere
- Marriage or addition of domestic partner
- Birth, adoption of child, or placement for adoption
- Court order (only applies to minor or disabled dependents)
- Death of a spouse, domestic partner, or dependent

As part of a new pool of eligible employees:

- Currently enrolled employees are allowed to change plans during the open enrollment period for new eligible employees when due to a documented merger/acquisition.
- Employees previously declining coverage can't enroll until the next open enrollment or through a special enrollment period due to a qualifying life event.

RETROACTIVITY

All subscriber terminations will be effective in the month the termination request was received unless termination in a future month was requested. Retroactive termination requests are not accepted. For subscriber's coverage to be terminated effective August 1, the request to terminate must be received by August 31. A termination request received in August can't be made effective retroactively back to July 1 or June 1.

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

MEDICAL PLAN CHANGES

Renewal

Groups can elect to make plan changes at renewal, which includes removing, replacing, or adding plans. These changes may impact premiums and the number of plans that a group can offer is based on the number of enrolled subscribers.

Employers with accounts in good standing can make plan change requests and must submit them on or before the last business day of the renewal effective month. Change requests must contain an email time and date stamp or date, postmark, or fax date stamp to prove the change was submitted on time. A plan change request received:

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

Deductible accumulation amounts may not be transferable.

Midyear plan changes

A change made outside of the renewal period is a midyear plan change as it results in a short contract of less than 12 months. Kaiser Permanente reserves the right to decline midyear plan change requests and grants requests only if *Midyear downgrades/replacements* and *Midyear upgrades/downgrades* requirements, found in the sections below, are satisfied. Midyear downgrades and upgrades plan change requests must include an attestation for health coverage changes. Midyear downgrades and upgrades plan change requests received:

- Before or on the 15th by 5 p.m. (PT) of the month are effective the first of the requested month, or a future effective month
- Between the 16th and by 5 p.m. (PT) of the last business day of the requested month are effective the first of the following month

Deductible accumulation amounts may not be transferable. The ACA requires the group to provide Summary of Benefits and Coverage (SBC) documents to their employees and dependents at least 60 days before the new plan's effective date.

Midyear downgrades/replacements

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

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

Downgrade due to financial reasons

Groups with high/low plans in place can:

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

Midyear plan additions due to mergers/acquisitions

For groups with high/low plans in place:

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

Midyear upgrades/downgrades

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

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

CROSSOVER GUIDELINES FOR HMO AND DEDUCTIBLE PLANS

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

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

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

CROSSOVER SCENARIOS FOR HMO PLANS

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

Scenarios	HMO to HMO	HMO to HDHP HMO (HSA-qualified) (or vice versa)	HDHP HMO (HSA-qualified) to HDHP HMO (HSA-qualified)
Employer/employee changes plan mid-accumulation period	Yes	Yes	Yes
Employee moves from one California region to another with same employer	Yes[7]	Yes	Yes[7]
Employee changes employer	No	No	No
Individual plan member enrolls in a group plan	No	No	No

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

HSA-qualified plan refers to the HDHP HMO plan only.

GRANDFATHERED (NONMETAL) CHIROPRACTIC/ACUPUNCTURE

The optional combined chiropractic/acupuncture coverage is available for grandfathered (nonmetal) plans for an added cost. This option is not available for the grandfathered HSA-qualified high deductible health plans (HDHP).

- If you offer chiropractic/acupuncture coverage, all subscribers and dependents must participate.
- Groups can only add this coverage at renewal and can discontinue coverage anytime up to 4 months before the group's renewal date or at renewal.

Chiropractic/acupuncture coverage provides members up to 20 combined visits per year for a copay of only $15 per visit.

METAL PLANS CHIROPRACTIC/ACUPUNCTURE

Combined coverage for chiropractic/acupuncture care is included on the following metal plans:

- Platinum 90 HMO 0/10 PCP + Child Dental Alt
- Platinum 90 HMO 250/30 PCP + Child Dental Alt
- Gold 80 HMO 0/35 PCP + Child Dental Alt
- Gold 80 HMO 1000/40 PCP + Child Dental Alt
- Silver 70 HMO 1900/65 PCP + Child Dental Alt
- Silver 70 HMO 2300/65 PCP + Child Dental Alt
- Silver 70 HMO 2900/65 PCP + Child Dental Alt

SUPPLEMENTAL FAMILY DENTAL PLANS (OPTIONAL)

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

- The optional supplemental family dental plans are available for an added cost.
- The employer may choose to offer one supplemental family dental plan to pair with their health plan and all subscribers and dependents will be enrolled.
- Our supplemental family dental plans cover adults and dependent children up to age 26, when dependent coverage is offered, at an extra cost. These plans do not substitute for the ACA required child dental coverage for members under 19 years old.
- The DeltaCare HMO family dental plan isn't offered with any PPO health plans.

FERTILITY BENEFIT – METAL PLANS ONLY

The optional fertility benefit is available for an added cost and only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier.

- Upon selection of this optional benefit, it will be added to all the metal HMO plans offered, as part of the original contract, or can be added or discontinued upon renewal.
- Fertility benefit is already included in all metal PPO plans.

RENEWAL

Notification

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

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

Renewal contracts are issued within 60 days following the contract renewal effective date. Renewal contracts are based on the information about enrollees the Plan has at the time the renewal is sent. Subsequent adjustments in enrollees will be reflected in the final contract. If a renewing group chooses to make changes to its current plan offering, then a renewal contract reflecting the changes will be provided shortly after processing is completed.

Renewal date change

Kaiser Permanente grants limited exceptions for renewal date changes upon underwriting review. Requests won't be considered to align with a dental plan, life insurance plan, or FSA/HSA HMO funding arrangement. To move forward with this voluntary process, new and existing groups must request the Renewal Date Change Request form and new groups must submit proof of the other carrier's new policy.

For questions or assistance, new groups may contact their assigned sales associate, and existing groups may email the Account Management Support Team at AMT@kp.org.

Existing groups wanting to align their renewal date with another carrier's health plan renewal date may only request this change if the new renewal date is on January 1 of the following year.

Group implications:

- An employer will receive a rate increase if the renewal date change results in the renewal date falling within a new rate period.
- For grandfathered (nonmetal) plans only, an employer's RAF can be adjusted if the employer changes to a new renewal date that is at least 6 months later than the current renewal date.
- To facilitate a renewal month change, a group must request an early contract termination and a new 12-month effective on the new date. Any applicable rate increases in effect on the new date will apply.

New groups may request to align their renewal date with another existing carrier's renewal date within 30 days of the original effective date. The new renewal effective date must be within 6 months of the original effective date. For example, if the original effective date is January 1, the proposed effective date can be no later than June 1.

RECERTIFICATION

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

A group that doesn't pass recertification or is unresponsive to recertification requests may be subject to termination. Contact a Kaiser Permanente representative for additional details.

RE-ENROLLMENT

If a group's coverage has been terminated for more than 60 days, the former group may re-enroll as a new group provided the group still qualifies for small group coverage. A new contract, group number, and effective date will be issued.

REINSTATEMENT

If a group's coverage has been terminated for less than 60 days, the former group may request reinstatement of their prior small group contract to avoid a gap in coverage. Consideration of this request is conditional provided premiums due are paid in full and they still qualify for small group coverage. Upon approval, the group retains its prior group number, renewal date, and grandfathered status.

STATEWIDE EMPLOYERS (INTER-REGIONAL SPLIT)

Kaiser Permanente contracts with employers separately as Kaiser Foundation Health Plan, Inc., Northern California Region and Kaiser Foundation Health Plan, Inc., Southern California Region. If Kaiser Permanente provides coverage for a group's employees residing in both Northern and Southern California, then separate regional contracts will be issued. The employer's location is typically considered the home region.

When renewing groups with one or more enrolled subscribers residing in the nonhome region, a second contract for the nonhome region will be required at renewal. Rates are based on headquarter location for both Northern California and Southern California contracts. Deductible and out-of-pocket maximum accumulations will transfer all accrued deductible to the new group.

- An employer must advise Kaiser Permanente when it moves its headquarters to a new California region by submitting an Address Change Request Form.
- An employer is not restricted to when they can change regions.
- The group is rated again upon renewal.

SECTION 6 – Existing accounts

CHANGE OF OWNERSHIP

Contract changes may be subject to Kaiser Permanente management approval. Contact your Account Manager or Account Management Support Team to process specific required documents.

Email changes to **amt@kp.org** or submit changes by fax to **800-369-8010.**

A change request received:

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

CAUSES FOR TERMINATION

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

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

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

SECTION 7 – Federal and state regulations

FEDERAL

Guaranteed availability

The federal law requiring guaranteed availability of coverage provides that small business employers can't be denied coverage for failure to satisfy minimum participation or contribution requirements. There are no exceptions to guaranteed availability based on a minimum contribution or participation requirements, but the law permits a health plan or insurer to limit enrollment in coverage to open and special enrollment periods.

If a small business employer doesn't meet contribution or minimum participation requirements, a health plan or insurer can limit its offering of coverage to an annual open enrollment period, which is the period from November 15 through December 15 of each year, for coverage for January 1, effective date. Groups who enroll during this time and opt for the guaranteed availability may be subject to recertification including termination upon their renewal if standard participation and contribution are not met.

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

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

- Kaiser Permanente doesn't require employees who are Working Aged to enroll in Medicare Parts A or B. Member copay and coinsurance will be the same as any other employee enrolled in that group's coverage. Penalties for enrolling late in Medicare Part B are waived while the individual is enrolled in qualifying group coverage.
- There's no balance billing per the normal terms in the *Evidence of Coverage* (*EOC*).
- If a group has 20 or more employees and an employee who is Working Aged enrolls in both Medicare Parts A and B, then the employee can enroll in the Kaiser Permanente Senior Advantage (KPSA) plan as an individual while still being covered under the group plan. This means Parts A and B are assigned to the KPSA plan, and through coordination of benefits with group coverage, the member has $0 deductible and $0 copay/coinsurance including prescription drugs. Covered benefits will be the same as employees on the group plan.
- For groups with 19 or fewer employees, the 65-year-old or older Medicare-eligible employee can enroll in the KPSA plan or remain on the group plan. They can't be enrolled in both.
- If an employee enrolls in both Medicare Parts A and B without enrolling in KPSA, then the member will typically pay $0 deductible and $0 copay/coinsurance through the coordination of benefits (COB) with Medicare and group coverage. However, prescription drugs are subject to applicable copay and cost shares including a separate drug deductible.

- If a former employee of a group becomes entitled to Medicare while being covered under COBRA continuation coverage (federal or state), then the member's eligibility for COBRA or Cal-COBRA will end. A former employee enrolled in or eligible for Medicare isn't eligible to enroll in Cal-COBRA.

Medicare is also primary when either of the following criteria is met:

- The employee is covered by a group health plan, is under 65, is on Medicare due to a disability, and the employer has fewer than 100 employees. If the group has 100 or more employees, the group is the primary payer.
- 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 payer during the first 30 months.

STATE

Binding arbitration

The state of California requires Kaiser Permanente to notify applicants at enrollment that binding arbitration is used. Signatures are captured to confirm that applicants have read and agreed to the binding arbitration policy.

Employees/applicants must be informed of Kaiser Permanente's use of binding arbitration when they choose to enroll in a Kaiser Permanente plan. Binding arbitration is used to settle member disputes in a less formal proceeding than a civil trial in state or federal court, and it can lead to quicker dispute resolutions.

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

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

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

If enrollments are collected using an online enrollment website: Employer groups using an online enrollment website are required to include the Kaiser Permanente arbitration agreement within the enrollment flow. California Arbitration Management System (CAMS) is a web service that can be added to an enrollment website. Kaiser Permanente's Arbitration Team will work with administrators (brokers, employer groups, third party administrators) to discuss CAMS or options for including the arbitration requirements. Screenshots are required for review and approval by the operational compliance arbitration department

Visit **business.kp.org** > Brokers > Working with KP for the Arbitration Group Requirements FAQs.

Cal-COBRA

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

An employee and/or eligible dependents are eligible for continuation of coverage under Cal-COBRA if employer 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.

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

Employees terminated for gross misconduct 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.

SECTION 8 – Business and proof of ownership documentation

We strive to make your enrollment process seamless. Kaiser Permanente staff will conduct state and local online searches to verify that a prospective customer is an active, legitimate small business eligible for small group coverage and that the owner, officer, or partner is actively engaged in the business and eligible for coverage. If the online search is unsuccessful, we may ask for the most current documents in the categories below; otherwise, the group may not be approved for coverage.

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

Kaiser Permanente reserves the right to request additional documentation at its sole discretion. If requested, submit the most current documents to avoid processing delays. See below for documents associated with different ownership types.

SOLE PROPRIETORSHIP

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

Submit <u>one</u> upon request:

- Current California business license[8]
- Fictitious business name filing

SOLE PROPRIETORSHIP (SPOUSES OR LEGAL DOMESTIC PARTNER) ELECTING TO BE A QUALIFIED JOINT VENTURE

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

Submit <u>one</u> upon request:

- Current California business license
- Fictitious business name filing

CORPORATION

Submit upon request:

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

OUT-OF-STATE (FOREIGN) CORPORATION

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

2. Required when unable to verify the above California web confirmation

Submit <u>one</u> upon request:

- Web confirmation with jurisdiction from the home state
- Statement and Designation by Foreign Corporation and Certificate of Good Standing from the home state
- Certificate of Qualification from the CA Secretary of State

SECTION 8 – Business and proof of ownership documentation

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

Submit one upon request:

- Statement of Partnership Authority (filed)
- State-certified application to register an LLP

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

Submit both upon request:

- Registration Form LLP-1 Application for Registration
- Web confirmation with jurisdiction from the home state or Certificate of Good Standing from the home state

LIMITED PARTNERSHIP (LP)

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

Submit upon request:

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

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

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

2. Required when unable to verify the above California web confirmation

Submit one upon request:

- Web confirmation with jurisdiction from the home state
- Registration Form LP-5 Application for Registration and Certificate of Good Standing from the home state

LIMITED LIABILITY COMPANY (LLC)

Submit upon request:

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

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

Submit upon request:

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

2. Required when the California web confirmation is unavailable – submit:

- Web confirmation with jurisdiction from the home state

NONPROFIT

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

- 501(c)(3) – Religious, educational, charitable, scientific, literary, testing for public safety, etc.
- 501(c)(1) – Corporations organized under Act of Congress (including federal credit unions)

Submit upon request

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

- California Secretary of State (kepler.sos.ca.gov) "active" web confirmation (nonprofit)
- National Federal Credit Union "active" web confirmation (nonprofit)
- IRS letter 501(c)(3)
- IRS application for exempt status

NATIONAL BANK CHARTER AND FEDERAL CREDIT UNION

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

Submit upon request

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

1. Kaiser Permanente is only required to offer a small group contract if the majority is met. We may issue a small group contract with Affordable Care Act provisions/protections that a large group doesn't provide. Colorado small groups must have between 1 and 100 employees. **2.** Actuarial value is the estimated portion of the cost of services that would be covered under the plan's design based on the experience of a standard population. The ACA allows a difference of +/- 2 points for actuarial value percentage within each tier. **3.** When a member is enrolled in a deductible plan with a health savings account (HSA) or health reimbursement arrangement (HRA), the group's contribution must be equitable amongst employees and when offered alongside another carrier. Groups are responsible for all setup and ongoing fees. **4.** Kaiser Permanente administration onboarding process may take up to 20 business days. **5.** Tax references relate to federal income tax only. Consult with a financial or tax adviser for information about state income tax laws. Federal and state tax laws and regulations are subject to change. **6.** Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan. **7.** Members must request that accumulation credits be applied to their new plan by calling the Deductible Product Service Team at 800-390-3507. **8.** Alternatively, professional license, seller's permit, business tax certificate, and city, county, or state documentation to validate business are acceptable.

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