



Small Group Enrollment Packet

Kaiser Permanente Health Insurance Coverage for California

Follow the eight easy steps to complete your enrollment for Kaiser Permanente group coverage.

KAISERQuotes
[.com](http://www.kaiserquotes.com)

phone: 1.877.752.4737
facsimile: 1.866.439.9993

Follow These Easy Steps to Enroll...

For Your Kaiser Permanente Small Group Coverage

Group Checklist



New Group Application

Please complete and sign the application.



Employee Enrollment Application

Each employee you wish to insure must complete, sign and date this form.



Declination of Coverage

All eligible employees declining coverage during this enrollment period must sign this form.



DE 6 (Quarterly Wage Report) Or Payroll Report

Please provide a copy of the most recent quarterly wage or payroll report.



Official Business Document

Please submit a copy of an official business document such as a Business License, Fictitious Name Statement, etc.



Proprietor/Partner/Corporate Officer Form (if applicable)

Must be signed by each proprietor/partner/corporate officer enrolling, and not listed on the DE 6 or payroll report.



Initial Premium Check

Please send a copy of the first month's premium check and make payable to "Kaiser Permanente".



Submit Enrollment Forms

Fax all documents to: **1.866.439.9993**

Or mail to: **KaiserQuotes.com**

Attn: Group Enrollment

750 Mendocino Avenue, Suite 4

Santa Rosa, CA 95401



NEW GROUP APPLICATION

This application for Kaiser Foundation Health Plan, Inc. (Health Plan), benefits is intended for the company below. Please use black ink.

EFFECTIVE DATE _____

Plan options

Please select the plan(s) you would like to offer.¹ For more information on the plans listed below, please contact your sales representative or broker to obtain a copy of the *Plan Highlights*.

Check here if you are selecting two or more plans from below.¹

| | | | | | |
|--|---|---|--|------------------------------------|-----------------------------------|
| Copayment plans | <input type="checkbox"/> \$50 plan | <input type="checkbox"/> \$30 plan | <input type="checkbox"/> \$20 plan | <input type="checkbox"/> \$15 plan | <input type="checkbox"/> \$5 plan |
| HSA-qualified deductible HMO plans | <input type="checkbox"/> \$30/\$3,000 plan with HSA | <input type="checkbox"/> \$0/\$2,700 plan with HSA | <input type="checkbox"/> \$0/\$2,000 plan with HSA | | |
| Deductible HMO plans | <input type="checkbox"/> \$40/\$2,000 plan | <input type="checkbox"/> \$30/\$1,500 plan | <input type="checkbox"/> \$30/\$1,000 plan | | |
| Deductible HMO plans with HRA² | <input type="checkbox"/> \$30/\$2,500 plan with HRA | <input type="checkbox"/> \$30/\$1,500 plan with HRA | | | |
| Point-of-service (POS) plans³ | <input type="checkbox"/> \$35 POS plan | <input type="checkbox"/> POS + GIFT ⁴ plan | | | |
| Preferred provider organization (PPO) plans³ | <input type="checkbox"/> \$40/\$2,500 plan with HSA | <input type="checkbox"/> \$40/\$1,000 plan | | | |

Dental plans and chiropractic benefits⁵

| | | | | | |
|--|---|---|--|-------------------------------------|---|
| Dental option (select only one plan) | Delta Dental Premier | <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan D | <input type="checkbox"/> Plan E | <input type="checkbox"/> Plan E with Ortho (requires at least 10 subscribers) |
| | Delta Dental PPO | <input type="checkbox"/> PPO D 1500 | <input type="checkbox"/> PPO E 1000 | <input type="checkbox"/> PPO E 1500 | |
| | DeltaCare HMO | <input type="checkbox"/> DeltaCare 10A | <input type="checkbox"/> DeltaCare 13B | | |
| Chiropractic option⁶ | <input type="checkbox"/> Chiropractic benefit | <input type="checkbox"/> Chiropractic/Acupuncture benefit for the \$40/\$1,000 PPO Plan only. | | | |

Company information

| | | | |
|--|--|--|---|
| Company name _____ | | Tax ID number _____ | |
| Street address (California only; no P.O. boxes) () _____ | | City () _____ | State _____ ZIP _____ |
| Phone _____ | | Fax ⁷ _____ | E-mail ⁷ _____ |
| Type of company: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Other _____ | | | |
| In business since _____ SIC/NASIC code _____ | | | |
| Including partners, proprietors, and employees of affiliates who are entitled to file a joint return, the company currently employs, in all locations, _____ individuals. Of those, _____ would be in a class eligible for coverage under Health Plan. | | | |
| Waiting period: How long must a new hire be employed before being offered health care benefits? Benefits are effective the first of the month following: (Check one.) <input type="checkbox"/> Date of hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days | | | |
| Do you have or have you previously had group insurance through Kaiser Permanente? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, group number _____ |
| Does your company currently have active health insurance? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, name of carrier _____ Number of employees enrolled _____ |
| Will you be offering another carrier's health care plans to your employees? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, name of carrier _____ |
| Do you have workers' compensation coverage? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, name of carrier _____ |
| Number of COBRA or Cal-COBRA enrollees (applying for health coverage) _____ | | | |
| What type of continuation coverage are you subject to? ⁸ <input type="checkbox"/> Federal COBRA (20+ employees) <input type="checkbox"/> Cal-COBRA (2-19 employees) | | | |

The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan and the out-of-network portion of the POS plan as well as the Delta Dental of California dental plans. The chiropractic benefit is administered by American Specialty Health Plans of California, Inc. The chiropractic/acupuncture benefit is administered by Private Healthcare Systems.

¹Groups with three to five subscribers are eligible to enroll in one or two Kaiser Permanente plans. Groups with six or more subscribers are eligible to enroll in one or more plans.

²Employer must fund at least 25 percent of the subscriber's deductible for the \$30/\$1,500 Deductible HMO Plan with HRA and at least 40 percent of the subscriber's deductible for the \$30/\$2,500 Deductible HMO Plan with HRA.

³For your group to be eligible for the \$35 POS Plan, the \$40/\$1,000 PPO Plan, or the \$40/\$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

⁴GIFT (gamete intrafallopian transfer) is an infertility treatment that involves removal, preparation, and reimplantation of ovum.

⁵Dental and chiropractic plans are only available when purchased with a health plan.

⁶Chiropractic benefits and chiropractic/acupuncture benefits cannot be combined with any HSA-qualified deductible HMO plan or the PPO with HSA plan.

⁷By giving Kaiser Permanente your fax number and e-mail address, you agree to receive faxes and e-mail from us.

⁸The employer retains all COBRA administrative responsibilities (such as notifying qualified beneficiaries of COBRA rights and processing COBRA elections) but delegates to Kaiser Foundation Health Plan, Inc. (Health Plan), the following clerical functions: billing Cal-COBRA members for applicable premiums (the employer authorizes Health Plan to add an administrative charge for this service); and terminating Cal-COBRA members for nonpayment of Cal-COBRA premiums or for expiration of the expected time limit that the employer specifies for Cal-COBRA coverage.

Corporate officers/Principal owners

Please use black ink.

| | | | | |
|--|--|---------------------|-------|-----|
| 1. Group officer (authorized contract signer) | Title | E-mail ¹ | | |
| 2. Group officer (authorized contract signer) | Title | E-mail ¹ | | |
| ■ Name and title of contact authorized to receive contract and make contract changes | Address | City | State | ZIP |
| ■ Name and title of contact authorized to receive billing statements | Address | City | State | ZIP |
| ■ Name and title of interested party authorized to access information about your account | <input type="checkbox"/> Check here if this person is authorized to make changes to your contract. | | | |

I authorize the following individual to act as broker of record for Kaiser Foundation Health Plan, Inc.

| | | | |
|--|-----------------------------|------------------|-----|
| Agent name | Agent e-mail ¹ | | |
| Agent license number | Agent phone number | Agent fax number | |
| Firm name | Kaiser Permanente Broker ID | | |
| Firm address | City | State | ZIP |
| Broker/Agent: If you have not registered as a firm or agent with Kaiser Permanente, please call Broker Administration at 1-800-789-4661 . | | | |

¹By giving Kaiser Permanente your e-mail address, you agree to receive e-mail from us.

As company principal/corporate officer, having authority to contract with Kaiser Foundation Health Plan, Inc. (Health Plan), I agree that my company will make the minimum contribution toward the health care premiums as described in the Enrollment Provisions, that prepaid monthly premiums should be posted to your account by the due date on your billing statement, that my company will use enrollment application forms that are provided or approved by Health Plan, and that my company will abide by the contract provisions.

Kaiser Permanente deductible plans are designed and priced based on the assumption that members participate in sharing the costs of their care. Employers funding cost share through direct reimbursements affects the way members utilize their plan, invalidating some of the assumptions we use to set benefits and pricing. Increased utilization results in an increase in premiums for all plan members. For this reason, Kaiser Permanente restricts employers from funding or directly reimbursing employee cost share, except as outlined below.

The undersigned group ("Group") agrees to the following conditions when Group chooses to offer one or more Kaiser Permanente small business deductible plans.

- Group may not fund or directly reimburse members for any Kaiser Permanente deductibles, coinsurance, or copayments with the exception of designated health reimbursement arrangement (HRA) plans. This includes employer reimbursements of employee cost share through employee flexible spending accounts (FSAs) or limited purpose FSAs.
- Group can fund an employee's health savings account (HSA) only if the employee is enrolled in a Kaiser Permanente HSA-Qualified Deductible HMO Plan. Contributions must be made in accordance with the federal tax laws for HSAs.

Small group contracted premiums are set annually and do not allow for small group re-rating. Brokers who have advised small business clients to fund or directly reimburse employees for deductible plan expenses in violation of our policies will not receive sales commissions (or rewards compensation) from Kaiser Permanente. Groups in violation of our policies may be subject to termination or non-renewal.

Your group may be subject to recertification prior to renewal.

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan, Inc. (KFHP), or Kaiser Permanente Insurance Company (KPIC) has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued. I certify, to the best of my knowledge and belief, all of the responses given are true, correct, and complete. I understand that if I have misrepresented or omitted any material fact, any coverage approved by KFHP or KPIC may be cancelled or the applicable dues/rates may be adjusted.

Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement:[†]

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes[†]) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage* and in the *Certificate of Insurance*.

[†]Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service Plans; 2) the PPO and Out-of-Area Indemnity Plans; and 3) the KPIC Dental Plans.

| | |
|---|----------------|
| _____ Authorized group officer (Please print name.) | _____ Title |
| X _____ Authorized group officer's signature (Use black ink.) | _____ Date |

Initial Payment by Electronic Check Authorization
for new small business accounts



RETURN FAX NUMBER _____ ATTN _____

IMPORTANT: Do not mail original application or check.

APPLICANT INFORMATION – ELECTRONIC CHECK AUTHORIZATION

Company name _____ Group number _____

I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to withdraw from my account the first month's premium only based on the facsimile copy of said premium check upon approval of the attached application. This payment will be electronically withdrawn from my bank account for the above-named group using the information provided.

Amount of premium: \$ _____

Financial institution _____

Transit routing number _____ Bank account number _____

Bank account holder name _____

Bank account holder address _____

This transaction will appear on your next bank statement as an Automated Clearing House (ACH) transaction.

If this item is returned unpaid, I authorize Kaiser Foundation Health Plan, Inc., to resubmit the item and authorize an additional returned payment fee for up to the maximum amount as allowed by the state to be charged to this account. I also acknowledge that Kaiser Permanente will not be responsible for any fees incurred if the original check is mailed and cashed and for any fees owed to the financial institution.



Authorized bank account holder signature _____ **Date** _____



Employer signature _____ **Title** _____ **Date** _____

ATTACH PRE-PRINTED VOIDED CHECK

The billing department needs the most accurate information to debit your account. Therefore, the voided check is necessary for processing. Please note we are unable to accept the following checks and account types: third-party checks, credit card checks, cashier's checks, money orders, traveler's checks, official checks, government checks.

**PLEASE ATTACH
PRE-PRINTED VOIDED CHECK HERE**

Confidentiality note: The documents accompanying this facsimile transmission may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient or the person responsible for delivering it to the recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information in the transmission is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments. Thank you.

Enrollment Form

Please print in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

To be completed by EMPLOYER

Company name*

Effective date of coverage*

Group number*

Enrollment unit/plan*

Part I:

New purchaser (Complete sections A, B, C.)

Existing policy (Complete Part II and sections A, B, C.)

Part II: Enrollment reason* (Please check one.)

Date of hire*

New hire

Part time to full time

Other

Open enrollment

Loss of coverage

To be completed by EMPLOYEE

Are you now or have you ever been a member of, or received care from, Kaiser Permanente? Yes No

If so, what is/was your medical record number (if known)? _____ In which state? _____

Name (Last, First, MI)*

Former name/Maiden (if any)

Home address*

Apt. no.

City

State

ZIP

Home phone*

Work phone

Social Security number

Date of birth*

E-mail

Gender* M F

Preferred spoken or written language (optional)

Ethnicity (optional)

B Family Information

For additional dependents, attach a separate sheet and please put the employee's name at the top.

Spouse Domestic partner

Gender

M F

Social Security number

Name (Last, First, MI):

Date of birth MM/DD/YY

Medical record number

Former last name (if any):

Child Student

Gender

M F

Social Security number

Name (Last, First, MI):

Date of birth MM/DD/YY

Medical record number

Relationship:

Child Student

Gender

M F

Social Security number

Name (Last, First, MI):

Date of birth MM/DD/YY

Medical record number

Relationship:

Child Student

Gender

M F

Social Security number

Name (Last, First, MI):

Date of birth MM/DD/YY

Medical record number

Relationship:

Do any of your dependents listed above live at another address? Yes No If yes, complete the following:

Name (Last, First, MI)

Address

Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for small claims court cases, claims subject to a Medicare appeals procedure, and, if my group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Employee/ Applicant signature*

Date*

Enrollment Form

General Instructions:

1. Please print legibly in black ink.
2. To be enrolled, you must live or work within one of the ZIP codes listed in the "Becoming a member" section of the enrollment booklet.
3. The employer must complete the first section, labeled "To be completed by EMPLOYER."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates as these affect your premiums.
5. The employee/subscriber must complete sections A through C.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), make a copy for your records to use with the Temporary Membership ID after the effective date.
8. All effective dates and child or student status will be made in accordance with the contractual agreement between the purchaser (your employer) and Kaiser Permanente.

Instructions for completing employer sections and sections A through C:

Employer sections: The employer must complete all fields to ensure we have correct account and enrollment reason information. The employer is responsible for confirming all information submitted by the subscriber, especially effective dates, as they affect premiums.

Section A: The subscriber must complete this section.

Section B: The subscriber must complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should only be marked if the dependent qualifies as an overage dependent attending school. Please contact your employer regarding the employer's rules for overage dependent students. A complete Student Certification Form may be required.

Section C: The subscriber must read this section, and sign and date at the bottom.



Serving the People of California

DE 6 QUARTERLY WAGE REPORT

PLEASE TYPE THIS FORM—DO NOT ALTER PREPRINTED INFORMATION

Approved Extension To _____

You must FILE this report even though you had no payment. If you had no payment, complete forms C and I. Instructions for completion are available on the back of this form.

QUARTER ENDED MARCH 31, 2005 DUE APR 1, 2005

DELINQUENT IF NOT POSTMARKED OR RECEIVED BY _____

MAY 1,

| | |
|------|-----|
| YR | QTR |
| 2005 | |

EMPLOYER ACCOUNT NO.

123-4567-8

JOHN SMITH
SMITH ENTERPRISES
123 HEALTH AVENUE
LOS ANGELES, CA 92069



| | | | | | | | | | | |
|------------------------|----------------|-----|-----|-----|---|--|--|--|--|--|
| DO NOT ALTER THIS AREA | | | | | | | | | | |
| DPT. USE ONLY | P | C | S | W | A | | | | | |
| | Mo. | Day | Yr. | WIC | | | | | | |
| | EFFECTIVE DATE | = | = | = | | | | | | |

B. NUMBER OF EMPLOYEES earning wages during or receiving pay for the pay periods that include the 12th day of calendar month.

1st Mo. 7 2nd Mo. 6 3rd Mo. 8

C. NO PAYROLL D. OUT OF BUSINESS / FINAL REPORT

A. Check ONE of the boxes below to indicate the type of subject wages and/or withholding you are reporting on this page. (See instructions for term A)

Page number _____ of _____

- 1. U1 AND D1 WAGES
- 2. U1 WAGES ONLY
- 3. D1 WAGES ONLY
- 4. U1 AND VOLUNTARY PLAN D1 WAGES
- 5. PERSONAL INCOME TAX WITHHELD

| E. SOCIAL SECURITY ACCOUNT NUMBER | F. EMPLOYEE NAME | | G. TOTAL SUBJECT WAGES PAID THIS QUARTER | | H. CALIFORNIA PERSONAL INCOME TAX WITHHELD THIS QUARTER | |
|-----------------------------------|------------------|----------------------------|--|----|---|----|
| | First Initial | Last Name | | | | |
| 123-45-6789 | I | Seymore Declining | 4,839 | 00 | 106 | 37 |
| 111-22-3333 | M | Feelgood Kaiser Permanente | 3,454 | 65 | 32 | 66 |
| 222-33-4444 | J | Wayne Kaiser Permanente | 4,460 | 00 | 36 | 50 |
| 555-55-5555 | J | Kennedy Terminated | 6,846 | 34 | 100 | 20 |
| 444-33-2222 | I | Care Part-time | 287 | 86 | 0 | 00 |
| 111-33-2222 | A | Easy Part-time | 40 | 50 | 0 | 00 |
| 555-11-5555 | B | Valor Kaiser Permanente | 5,663 | 74 | 64 | 98 |
| 001-11-2222 | D | Best Kaiser Permanente | 7,800 | 00 | 281 | 88 |
| | | | | | | |
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| | | | | | | |
| | | | | | | |

I. I declare that the information herein is true and correct to the best of my knowledge and belief.

Date _____ Phone (____) _____

Title _____
(Owner, Accountant, Preparer, etc.)

Signature _____

| | | | |
|----------------------------|----|----------------------------|--|
| I. TOTALS - THIS PAGE ONLY | | K. TOTALS - THIS PAGE ONLY | |
| 33,392 | 09 | | |

| | | | |
|-----------------------------|----|-----------------------------|----|
| L. GRAND TOTALS - ALL PAGES | | M. GRAND TOTALS - ALL PAGES | |
| 33,392 | 09 | 622 | 59 |

(If not listed on DE 6)

To establish the relationship between proprietors, partners, and/or corporate officers to the below-referenced company, please complete and return this form.

I attest that, although my name does not appear on the DE 6 wage report of the below-named company, the following conditions are true:

1. I am a sole proprietor, partner of a partnership, or corporate officer.
2. I actively work at the below-named company.
3. I draw wages, dividends, or other distributions from the below-named company on at least a monthly basis and am not eligible for group health coverage from any other employment.
4. I work on a permanent, full-time basis for the below-named company for at least 20 hours per week.
5. I satisfied the designated waiting period before coverage became effective.
6. I must provide, upon request from Kaiser Permanente, a copy of my company's fictitious name statement, DBA, legal partnership agreement and Schedule K, Articles of Incorporation, Schedule C, current business license, or current professional license.

I understand that this information may be subject to verification and agree to provide Kaiser Foundation Health Plan, Inc., with any information necessary to do so. I also understand that failure to meet the above conditions may result in denial or termination of group health coverage from Kaiser Foundation Health Plan, Inc., for the below-named company.

X

Proprietor, partner, or
corporate officer's signature

Print proprietor, partner, or corporate officer's name

Title

Date

Company name

X

Proprietor, partner, or
corporate officer's signature

Print proprietor, partner, or corporate officer's name

Title

Date

Company name

STUDENT CERTIFICATION

Requirements for dependent student coverage:

- Must be enrolled in an accredited institution
- Must be dependent upon subscriber for support
- Must be unmarried
- Units required are determined by the employer
- Must be younger than age 24

Dependent's name Dependent's medical record number

Date of birth (MM/DD/YY) Dependent's Social Security number

School name

School address City State ZIP

Student ID number Number of units carried

Subscriber's name Subscriber's medical record number

Group ID

I certify that the dependent shown meets all of the requirements for coverage on my account. I understand the Health Plan coverage for this dependent will terminate on the first day of the month following the date that any one of these requirements is no longer met.

X

Subscriber's signature

Social Security number

Date

Employee: Return completed form to your employer.

ENROLLMENT PROVISIONS

Enrollment eligibility and cost contributions

The following summary provides some important details about enrollment eligibility, employer contributions, and payroll deductions to cover the cost of coverage. The **Group Agreement** provides more information about eligibility, participation, and contribution requirements.

COMPANY ELIGIBILITY FOR COVERAGE

Your company qualifies for our small group coverage if you have at least two but no more than 50 full-time employees worldwide (working at least 30 hours per week). You may also choose to offer health care coverage to your employees working between 20 and 29 hours per week.

To be eligible for a multiple plan offering, your company must have at least three subscribers who enroll. Groups with three to five subscribers are eligible to enroll in a maximum of two Kaiser Permanente plans. Groups with six or more subscribers are eligible to enroll in one or more plans.

ENROLLMENT GUIDELINES

Your group must enroll a minimum of one employee in our small group coverage, with at least 70 percent of eligible employees covered by any group health plan (for example, through their employer or their spouse's employer).

For your group to be eligible for the \$35 POS Plan or the PPO plans, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one HMO plan. When a Kaiser Permanente Insurance Company (KPIC) POS or PPO plan is offered, at least 70 percent of all enrolled employees must be enrolled in an HMO plan. Combined enrollment in KPIC POS and PPO insurance plans may not exceed 30 percent.

EMPLOYEE AND FAMILY DEPENDENT ELIGIBILITY

Employees and their family dependents (spouse/domestic partner, unmarried children to age 19, and students to age 24) are eligible for coverage if the employee lives or works within our ZIP code service area.

ANNUAL OPEN ENROLLMENT

Once a year, employees must be given the opportunity to change plans or add dependents not previously enrolled. Employees and/or dependents who do not enroll when first eligible must wait until the annual open enrollment period to enroll, unless enrollment is due to new dependents or loss of other coverage.

EMPLOYER'S CONTRIBUTION AND PAYROLL DEDUCTION

Your minimum cost contribution must be the greater dollar amount of the following scenarios: (a) 50 percent of the under-30 employee-only rate for the least expensive Kaiser Permanente plan offered by your company, or (b) the required equal-dollar-amount contribution to an alternate plan your company may offer. Any part of the cost not paid by your company must be collected from the employees through payroll deduction. In addition to contributing toward an employee's health plan premium, an employer may also contribute toward the employee's health savings account.

An employer must fund 25 percent of the subscriber's deductible for the \$30/\$1,500 Deductible HMO Plan with HRA and 40 percent of the subscriber's deductible for the \$30/\$2,500 Deductible HMO Plan with HRA.

If you choose to offer multiple plans, your minimum contribution will be determined from the least expensive plan you choose.

FULL-MONTH COVERAGE

Kaiser Permanente membership begins on the first day of the month following the waiting period that you specify for new hires and continues through the end of the termination month.

WORKERS' COMPENSATION

All enrollees must be covered by workers' compensation unless they are not required by law to be covered. Owner-partners are not required to be covered by workers' compensation.

GROUPS THAT DO NOT QUALIFY AS NEW BUSINESS

If your group falls into one of the categories below, it does not qualify for new business rates. Your group will be issued the same risk adjustment factor (RAF) as the group it has spun off from.

- A resold existing Kaiser Permanente, CaliforniaChoice, or Choice Solution group
- A group previously included in an existing Kaiser Permanente contract that now wishes to enroll directly with Kaiser Permanente (for example, associations) will have the RAF determined by Actuarial.