KAISER PERMANENTE®

Small Business
NEW GROUP APPLICATION

Fax to your Kaiser Permanente sales representative or your broker.

Effective date ____ / ____ / ____

1 COMPANY INFORMATION

Company name

Doing business as (DBA) | Website

Type of company ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ Limited liability company (LLC) ☐ Other:

In business since / / | Federal Tax ID (EIN) Number | SIC code (4 digits)

Street address (no P.O. boxes) | City | State | ZIP | County

Office phone ( ) – | Ext. | Fax ( ) –

Do you have workers' compensation coverage? ☐ Yes ☐ No ☐ Pending **If *Yes* or *Pending*, name of carrier:**

2A EMPLOYER ELIGIBILITY

In determining the number of employees or eligible employees, affiliated companies that are eligible to file a combined tax return for purposes of state taxation shall be considered 1 employer and must apply as 1 employer.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No

2B EMPLOYEE COUNT

Please provide the total number of employees **(full-time and part-time).**

Authorized company signer's initials _______________ Total _______________

Note: If the total number of employees noted above is 100 or less, skip the following and go to Eligible Employees section.

If your total number of employees noted above is more than 100, please provide the total number of **full-time and full-time-equivalent employees** on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to the California Small Group Law (1357.500)(k)(3) or your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or previous calendar year.

Authorized company signer's initials _______________ Total _______________

2C ELIGIBLE EMPLOYEES

Please provide the total number of **eligible employees.** Please refer to the Small Business Guidelines for information on eligible employees.

Authorized company signer's initials _______________ Total _______________

3 CONTINUATION COVERAGE[1]

What type of continuation coverage is your company subject to? ☐ Federal COBRA (20+ employees) ☐ Cal-COBRA (2–19 employees)

How many Federal COBRA applications will you be submitting as of the group's effective date? _____________
For Cal-COBRA applications, contact Member Services at **800-464-4000.**

Will a Third-Party Administrator (TPA), including a broker, administer Federal COBRA? ☐ Yes* ☐ No

Note: A TPA cannot administer Cal-COBRA.
*If yes, please fill out section 10, "Third-Party Administrator (TPA) Contact Information."

Company name (please print): ______________________

4 COMPANY PREMIUM CONTRIBUTION

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.

Will you be offering dependent coverage? ☐ Yes ☐ No*

*For groups with 49 employees or less, dependent coverage is optional. Employees may not enroll any dependents unless coverage is offered by employer. Groups with 50 or more full-time and full-time-equivalent employees are subject to Employer Shared Responsibility and therefore are required to offer dependent children coverage.[2]

Company contribution for employees:	Company contribution for dependents is optional, if dependent coverage is offered. (enter 0 if none):
$ or % of the premium	$ or % of the premium

Percentage of the premium is based on the following **(select 1 only):**

☐ Lowest-priced Kaiser Permanente medical plan offered by the employer ☐ All Kaiser Permanente medical plans offered by the employer

5 OTHER MEDICAL INSURANCE

Does your company or affiliated company(ies) have or has it ever had group insurance directly through Kaiser Permanente? If *Yes*, please provide the customer ID, group number, and company name.

☐ Yes ☐ No Customer ID #/Group #/Company Name:

Does your company currently have active group health insurance?

☐ Yes ☐ No Name of carrier:

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?

☐ Yes ☐ No Name of carrier: Number of employees enrolled:

6 ERISA STATUS

Is your company subject to ERISA?[3] ☐ Yes ☐ No If you do not select an answer, we will record your status as *Yes*.

7 CONTRACT SIGNER INFORMATION

There is only 1 contract signer. This is the person who will be responsible for signing the group agreement and the principal person authorized to make membership or contractual changes to your account.

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name	
Street address	City	State	ZIP
Office phone ( ) –	Ext.	Fax ( ) –	Cell phone ( ) –
Email	How should we correspond with you? (select 1 only) ☐ Email ☐ Fax ☐ Mail		

8 CONTRACT DELIVERY PREFERENCE

We will deliver your Kaiser Foundation Health Plan/Kaiser Permanente Insurance Company contracts online in a PDF file at **businessnet.kp.org** unless you indicate below that you would like your printed contract(s) mailed to you.

☐ I want to receive my contract(s) by mail.

KAISER PERMANENTE®

Company name (please print): ____________________

9 BILLING CONTACT INFORMATION

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information, but is not authorized to sign the group agreement or to make contractual changes to your account. Only 1 billing contact is allowed. **If you're using a Third-Party Administrator (TPA), including a broker acting as a TPA for billing administration, please proceed to section 10.**

☐ Check here if same as contract signer.

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name

☐ Check here if this person is also authorized to make changes to your contract.

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only) ☐ Email ☐ Fax ☐ Mail

10 THIRD-PARTY ADMINISTRATOR (TPA) CONTACT INFORMATION

The TPA contact is an external person, company, or broker that is contracted for the purpose of administering the group's billing and enrollment or solely administering your COBRA benefits. This person will have access to group information, but is not authorized to sign the group agreement or to make contractual changes to your account.

TPA company name

☐ TPA is for Federal COBRA administration only

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only) ☐ Email ☐ Fax ☐ Mail

Company name (please print): ____________________

11 INTERESTED PARTY

An interested party is an individual authorized to access your group's information, such as enrollees, premium contributions, and plan selections. An interested party may also be authorized to make changes to your contract, such as adding/deleting plans, adding/deleting employees, changing waiting periods, or increasing/decreasing company premium contributions.

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name

☐ Check here if this person is also authorized to make changes to your contract.

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only) ☐ Email ☐ Fax ☐ Mail

ADDITIONAL INTERESTED PARTY

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First name	MI	Last name

☐ Check here if this person is also authorized to make changes to your contract.

Street address	City	State	ZIP

Office phone	Ext.	Fax	Cell phone
( ) –		( ) –	( ) –

Email	How should we correspond with you? (select 1 only) ☐ Email ☐ Fax ☐ Mail

12 PROPRIETOR, PARTNER, AND CORPORATE OFFICER INFORMATION

Please list all Proprietor, Partner, and Corporate Officer names below.

Name	Title
Name	Title
Name	Title

Company name (please print): ____________________

13 AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

To be completed by your Kaiser Permanente–appointed agent/broker after completion of this application. If you are a broker who has not registered as a firm or agent with Kaiser Permanente, please call Broker Sales at **800-789-4661, option 4.**

Notice to agent or broker:
If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies under current law.

You must select Yes or No:
I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Yes ☐ No

Agent name			License number
Office phone ( ) –	Fax ( ) –		Cell phone ( ) –
Email			
Firm name			Kaiser Permanente broker firm ID
Street address	City	State	ZIP
Agent/broker signature X *Marc Derendinger*			Date

14 MEDICAL PLANS[4]

Please select the plan(s) you would like to offer. For more information on the plans listed below, contact your sales representative or agent/broker.

Bronze	☐ Bronze 60 HMO 6000/70 w/ Child Dental ☐ Bronze 60 HSA HMO 4500/40% w/ Child Dental	☐ Bronze 60 PPO 6000/70 w/ Child Dental*
Silver	☐ Silver 70 HMO 1000/50 w/ Child Dental** ☐ Silver 70 HMO 1500/45 w/ Child Dental	☐ Silver 70 PPO 1500/45 w/ Child Dental*
Gold	☐ Gold 80 HMO 0/35 w/ Child Dental ☐ Gold 80 HRA HMO 2000/30 w/ Child Dental	☐ Gold 80 HMO 500/30 w/ Child Dental** ☐ Gold 80 PPO 0/35 w/ Child Dental*
Platinum	☐ Platinum 90 HMO 0/15 w/ Child Dental** ☐ Platinum 90 HMO 0/20 w/ Child Dental	☐ Platinum 90 PPO 0/20 w/ Child Dental*

Child Dental We're required to include child dental benefits with your medical plan(s). When employees and their dependents enroll in the HMO medical plan(s) you've chosen, we'll also enroll them in a separate child dental plan underwritten by Delta Dental of California. PPO medical plan 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.
*PPOs can only be offered when Kaiser Permanente is the sole carrier. Only 1 PPO plan is allowed per contract.
**Chiropractic and acupuncture benefits are included with these plans.

Groups selecting the Gold 80 HRA HMO 2000/30 plan above must fund the HRA HMO for each enrolled employee. The allowable funding range is $300 to $700 per employee. If the group covers dependents, the allowable funding range per family is $600 to $1,400.

If you have selected an HSA HMO or HRA HMO medical plan above, please indicate if you would also like Kaiser Permanente to administer your plan.
HSA administered through Kaiser Permanente? ☐ **Yes** ☐ **No**
HRA administered through Kaiser Permanente? ☐ **Yes** ☐ **No**
If you have selected *Yes*, a Kaiser Permanente representative will contact you to provide more information on your next steps.

To help you make an informed choice, Summary of Benefits and Coverage (SBC) documents for all our plans are available at **kp.org/smallbusiness-sbc/ca**. SBCs summarize important information about our health coverage options in a standard format, so you can easily compare benefits and coverage offered by Kaiser Permanente and other carriers.

Company name (please print): ____________________

15 DENTAL PLANS

FAMILY DENTAL PLANS[5]

Our family dental plans cover the entire family, including adults and dependent children up to age 26. However, a family dental plan is not a substitute for the child dental coverage required by ACA regulations for members under age 19. Please select only 1 plan.

KPIC Fee-for-service (Premier)	☐ Plan C	☐ Plan D	☐ Plan E	☐ Plan E with Ortho **(requires at least 10 subscribers)**
KPIC PPO	☐ PPO D 1500	☐ PPO E 1000	☐ PPO E 1500	
DeltaCare HMO	☐ 10A HMO	☐ 13B HMO		

16 INFERTILITY BENEFIT

The optional infertility benefit is available only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier. If you select this benefit, it will be added to all the HMO plans you offer.

☐ Add infertility benefit

17 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

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.

All groups may be subject to a recertification process. Recertification is done to ensure that groups meet all Kaiser Permanente requirements and those set forth in the California Health and Safety Code and the Affordable Care Act.

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

KPIC plans are offered alongside KFHP HMO plans and are intended to provide employees of groups eligible for KFHP's HMO plans an insurance-based plan alternative.

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining health insurance coverage.

18 FOOTNOTE INFORMATION

[1] The 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. If you use a Third-Party Administrator (TPA), please contact your Kaiser Permanente representative.

[2] For more information on Employer Shared Responsibility, see section 4980(H)(c)(2) of the Internal Revenue Code.

[3] ERISA is a federal law that sets minimum standards for employee benefit plans established by private employers and employee organizations. Many group health plans are subject to ERISA, although government and church plans generally are not. If you're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal adviser before responding.

[4] You're eligible to offer a choice of plans to your employees.
- Groups with 1 to 5 enrolled subscribers can offer a choice of up to 3 Kaiser Permanente plans.
- Groups with 6 or more enrolled subscribers can offer a choice of 1 or more Kaiser Permanente plans.

[5] Dental plans are available only when purchased with a medical plan. If you choose a dental plan, all eligible subscribers and dependents must participate. A medical PPO plan member living outside California is not eligible for the DeltaCare HMO family dental plan.

Company name (please print): ____________________

19 SIGNATURE

As a company principal/corporate officer, having authority to contract with KFHP and KPIC, I agree that:

- Prepaid monthly premiums will be posted to Kaiser Permanente's account by the due date on the Kaiser Permanente billing statement.
- My company will use employee enrollment application forms provided or approved by KFHP and KPIC for new employees.
- The eligibility data provided by my company to Kaiser Permanente will include coverage effective dates for my company's employees in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods may not exceed 90 days. My company acknowledges that the effective date of coverage for new employees and their eligible family dependents will be on the 1st of the month and will not exceed the waiting period established by my company.
- My company will abide by the contract provisions.

I have read, understood, and agreed to Kaiser Permanente's *Small Business Guidelines*, which may be included with my rate quote or, if not included, is available at **kp.org/smallbusinessguidelines/ca**.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I will comply with the 70% participation provision, as outlined in the small business guidelines.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/ca**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I performed an act or practice constituting fraud or made an intentional misrepresentation of material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

I understand that if KFHP or KPIC intends to rescind or terminate my coverage, I will be sent a notice via regular certified mail at least 30 days prior to the effective date of the rescission or termination explaining the reasons for the intended rescission or termination and notifying me of my right to appeal that decision to the Department of Managed Health Care director or the Department of Insurance commissioner. I understand that after 24 months following the issuance of my KFHP health plan contract/KPIC health insurance policy, KFHP/KPIC shall not rescind my plan contract/policy for any reason, and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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*.

Authorized company signer (please print name)	Title (please print)
Signature required for all Kaiser Permanente plans X	Date

*Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the out-of-network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

EMPLOYEE ENROLLMENT

INSTRUCTIONS

Please print neatly.

Be sure to fill in the enrollment form completely. Missing or inaccurate information will delay enrollment processing.

Employer

1. Complete section 1 on the enrollment forms.
   1A. If enrollment reason is loss of coverage or other, the event must be one of the special enrollment triggering events listed below:
   - Increase in an employee's hours so that he or she meets your requirement for medical plan eligibility
   - Return from a leave of absence
   - Involuntary termination or loss of other group coverage
   - A dependent loses coverage elsewhere
   - Marriage or addition of a domestic partner
   - Birth
   - Adoption of a child or placement for adoption
   - Court order
   - Death of a spouse, domestic partner, or dependent
2. Give each enrolling employee an enrollment form to complete.
3. Confirm that the information provided by employees on their enrollment forms is complete and accurate.
4. Return the completed enrollment forms to your broker or Kaiser Permanente.

Employee

1. Complete sections 2 through 4.
2. Sign and date the form.
3. Make a copy of the form for your records.

This form serves as your temporary Kaiser Permanente member ID.
Please make a copy and keep it until you receive your official member ID.

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

See instructions on page 1 before completing this form. Make a copy for your records.

1 TO BE COMPLETED BY EMPLOYER ☐ New group account ☐ Existing account

Company name	Customer ID (if assigned)	Date of coverage to be effective / /

Plan selection	Employee classification (if applicable)

Employee last name	Employee first name	MI

Enrollment reason (Please check 1) ☐ New group account ☐ New hire ☐ Open enrollment ☐ Part-time to full-time ☐ Loss of coverage ☐ Other:

If you have an **existing** account, please fax this form to **858-614-3345** (SCAL), **858-614-3344** (NCAL), or email **csc-sd-sba@kp.org**.

2 TO BE COMPLETED BY EMPLOYEE

Have you ever been a member of, or received care from, Kaiser Permanente in California? ☐ Yes ☐ No

If so, under what medical record number (if known)	Social Security number	Former/Maiden name

Last name	First name	MI	Preferred language (optional)

Home address (no P.O. boxes)

City	State	ZIP	County

Date of birth	Gender	Home phone	Office phone
/ /	☐ M ☐ F	( ) –	( ) –

If you decline coverage for yourself or an eligible dependent, you can only enroll or change your coverage during an annual open enrollment period established by your employer, or during a special enrollment period if you have experienced a triggering event. You must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court orders that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

3 FAMILY INFORMATION (Please list only those family members to be enrolled.)

☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	
☐ Dependent	Date of birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Social Security number
Name (Last, First, MI)		Medical record number (if known)	

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

Name (Last, First, MI)	Address

4 SIGNATURE

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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, 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*.

Employee signature X	Date
Employee name (please print)	Title (please print)

** Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the out-of-network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

Medical plan rates

Kaiser Permanente for small businesses ■ For effective dates January 1–June 1, 2017 ■ California

Rate rules for 2017 metal plans

Understand the way rates are set in the small group market.

You'll use these factors to calculate rates for your 2017 metal plans:

- **Rate areas** — There are 19 geographical rate areas.
  - The rating areas for metal plans are assigned based on the employer's physical, authenticated address and defined using county boundaries (5-digit ZIP code + county), regardless if a group is located outside the Kaiser Permanente service area in California.
  - If a group is located out of state, then rating area 4 is assigned. When a group is located outside the Kaiser Permanente service area in California or out of state, then only employees living in the service area are eligible to enroll based on their home ZIP code + county.
- **Individual age categories** — Rates are calculated by the age of each covered member on the plan's effective date. This includes:
  - your employee
  - employee's spouse or domestic partner
  - a maximum of three children under the age of 21 (additional children under 21 are covered at no additional cost)
  - all adult children ages 21 to 25, including those in school or living at home

What's included with child dental coverage?

Child dental services is one of the essential health benefits required to be provided in conjunction with Affordable Care Act (ACA)-compliant medical plans. Employees and their dependents enrolled in an ACA-compliant HMO medical plan will also be enrolled in a separate child dental plan based on their level of coverage and underwritten by Delta Dental of California.

PPO medical plan members enrolled in any of our ACA-compliant plans receive child dental PPO benefits as part of their medical coverage and not as a separate plan.

Child dental services apply to all members under 19 years old who are on an ACA-compliant plan.

KAISER PERMANENTE®

Rate Areas 7, 9

For effective dates January 1–June 1, 2017
*Also available in Covered California

Small Business medical plan rates

Age on 2017 effective date	Bronze 60 HMO 6300/75* + Child Dental	Bronze 60 HDHP HMO 4800/40%* + Child Dental	Bronze 60 PPO 6300/75 + Child Dental	Silver 70 HMO 1000/50* + Child Dental Alt	Silver 70 HMO 2000/45* + Child Dental	Silver 70 HDHP HMO 2000/20%* + Child Dental	Silver 70 PPO 2000/45 + Child Dental
0–18†	$151.69	$152.25	$236.85	$196.18	$204.24	$183.28	$343.60
19–20	$137.70	$138.26	$236.85	$182.19	$190.25	$169.29	$343.60
21	$216.85	$217.73	$373.00	$286.91	$299.61	$266.60	$541.11
22	$216.85	$217.73	$373.00	$286.91	$299.61	$266.60	$541.11
23	$216.85	$217.73	$373.00	$286.91	$299.61	$266.60	$541.11
24	$216.85	$217.73	$373.00	$286.91	$299.61	$266.60	$541.11
25	$217.71	$218.60	$374.49	$288.05	$300.81	$267.67	$543.27
26	$222.05	$222.95	$381.95	$293.79	$306.80	$273.00	$554.09
27	$227.25	$228.18	$390.90	$300.68	$313.99	$279.40	$567.08
28	$235.71	$236.67	$405.45	$311.87	$325.68	$289.80	$588.18
29	$242.65	$243.64	$417.38	$321.05	$335.26	$298.33	$605.50
30	$246.12	$247.12	$423.35	$325.64	$340.06	$302.59	$614.16
31	$251.32	$252.34	$432.30	$332.52	$347.25	$308.99	$627.14
32	$256.53	$257.57	$441.25	$339.41	$354.44	$315.39	$640.13
33	$259.78	$260.84	$446.85	$343.71	$358.93	$319.39	$648.25
34	$263.25	$264.32	$452.82	$348.30	$363.73	$323.66	$656.91
35	$264.99	$266.06	$455.80	$350.60	$366.12	$325.79	$661.23
36	$266.72	$267.80	$458.78	$352.89	$368.52	$327.92	$665.56
37	$268.45	$269.55	$461.77	$355.19	$370.92	$330.05	$669.89
38	$270.19	$271.29	$464.75	$357.48	$373.31	$332.19	$674.22
39	$273.66	$274.77	$470.72	$362.08	$378.11	$336.45	$682.88
40	$277.13	$278.25	$476.69	$366.67	$382.90	$340.72	$691.54
41	$282.33	$283.48	$485.64	$373.55	$390.09	$347.12	$704.52
42	$287.32	$288.49	$494.22	$380.15	$396.98	$353.25	$716.97
43	$294.26	$295.45	$506.16	$389.33	$406.57	$361.78	$734.28
44	$302.93	$304.16	$521.07	$400.81	$418.55	$372.44	$755.93
45	$313.12	$314.40	$538.61	$414.29	$432.64	$384.97	$781.36
46	$325.27	$326.59	$559.49	$430.36	$449.41	$399.90	$811.66
47	$338.93	$340.31	$582.99	$448.43	$468.29	$416.70	$845.75
48	$354.54	$355.98	$609.85	$469.09	$489.86	$435.90	$884.71
49	$369.94	$371.44	$636.33	$489.46	$511.13	$454.82	$923.13
50	$387.29	$388.86	$666.17	$512.41	$535.10	$476.15	$966.42
51	$404.42	$406.06	$695.64	$535.08	$558.77	$497.21	$1,009.17
52	$423.28	$425.00	$728.09	$560.04	$584.84	$520.41	$1,056.24
53	$442.36	$444.16	$760.91	$585.29	$611.20	$543.87	$1,103.86
54	$462.96	$464.85	$796.35	$612.54	$639.67	$569.20	$1,155.27
55	$483.57	$485.53	$831.78	$639.80	$668.13	$594.52	$1,206.67
56	$505.90	$507.96	$870.20	$669.35	$698.99	$621.98	$1,262.41
57	$528.45	$530.60	$908.99	$699.19	$730.15	$649.71	$1,318.68
58	$552.52	$554.77	$950.39	$731.04	$763.41	$679.30	$1,378.74
59	$564.45	$566.74	$970.91	$746.82	$779.88	$693.97	$1,408.50
60	$588.52	$590.91	$1,012.31	$778.66	$813.14	$723.56	$1,468.57
61	$609.34	$611.81	$1,048.12	$806.21	$841.90	$749.15	$1,520.51
62	$623.00	$625.53	$1,071.62	$824.28	$860.78	$765.95	$1,554.60
63	$640.13	$642.73	$1,101.08	$846.95	$884.45	$787.01	$1,597.35
64+	$650.55	$653.19	$1,119.00	$860.73	$898.83	$799.80	$1,623.33

†HMO 0–18 rates include the cost of $13.99 for child dental coverage. PPO plans include the cost of child dental coverage in the overall rate.

KAISER PERMANENTE®

Rate Areas 7, 9

For effective dates January 1–June 1, 2017
*Also available in Covered California

Small Business medical plan rates

Age on 2017 effective date	Gold 80 HMO 0/30* + Child Dental	Gold 80 HMO 500/35* + Child Dental Alt	Gold 80 HRA HMO 2000/30 + Child Dental	Gold 80 PPO 0/30 + Child Dental	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/15* + Child Dental	Platinum 90 PPO 0/15 + Child Dental
0–18†	$232.92	$231.22	$218.70	$377.43	$259.06	$255.78	$417.75
19–20	$218.93	$217.23	$204.71	$377.43	$245.07	$241.79	$417.75
21	$344.78	$342.09	$322.38	$594.37	$385.94	$380.77	$657.87
22	$344.78	$342.09	$322.38	$594.37	$385.94	$380.77	$657.87
23	$344.78	$342.09	$322.38	$594.37	$385.94	$380.77	$657.87
24	$344.78	$342.09	$322.38	$594.37	$385.94	$380.77	$657.87
25	$346.16	$343.46	$323.66	$596.75	$387.48	$382.30	$660.51
26	$353.05	$350.30	$330.11	$608.64	$395.20	$389.91	$673.66
27	$361.33	$358.51	$337.85	$622.90	$404.46	$399.05	$689.45
28	$374.77	$371.85	$350.42	$646.08	$419.52	$413.90	$715.11
29	$385.81	$382.80	$360.74	$665.10	$431.87	$426.09	$736.16
30	$391.32	$388.27	$365.90	$674.61	$438.04	$432.18	$746.69
31	$399.60	$396.48	$373.63	$688.88	$447.30	$441.32	$762.48
32	$407.87	$404.70	$381.37	$703.14	$456.57	$450.45	$778.27
33	$413.04	$409.83	$386.21	$712.06	$462.36	$456.17	$788.13
34	$418.56	$415.30	$391.36	$721.57	$468.53	$462.26	$798.66
35	$421.32	$418.04	$393.94	$726.32	$471.62	$465.31	$803.92
36	$424.08	$420.77	$396.52	$731.08	$474.71	$468.35	$809.19
37	$426.83	$423.51	$399.10	$735.83	$477.79	$471.40	$814.45
38	$429.59	$426.25	$401.68	$740.59	$480.88	$474.44	$819.71
39	$435.11	$431.72	$406.84	$750.10	$487.06	$480.54	$830.24
40	$440.63	$437.19	$412.00	$759.61	$493.23	$486.63	$840.76
41	$448.90	$445.40	$419.73	$773.87	$502.49	$495.77	$856.55
42	$456.83	$453.27	$427.15	$787.54	$511.37	$504.52	$871.68
43	$467.86	$464.22	$437.46	$806.56	$523.72	$516.71	$892.74
44	$481.65	$477.90	$450.36	$830.34	$539.16	$531.94	$919.05
45	$497.86	$493.98	$465.51	$858.27	$557.30	$549.84	$949.97
46	$517.17	$513.14	$483.56	$891.56	$578.91	$571.16	$986.81
47	$538.89	$534.69	$503.87	$929.00	$603.22	$595.15	$1,028.26
48	$563.71	$559.32	$527.08	$971.80	$631.01	$622.56	$1,075.62
49	$588.19	$583.61	$549.97	$1,014.00	$658.41	$649.60	$1,122.33
50	$615.77	$610.98	$575.76	$1,061.55	$689.29	$680.06	$1,174.96
51	$643.01	$638.00	$601.23	$1,108.50	$719.78	$710.14	$1,226.94
52	$673.01	$667.76	$629.28	$1,160.21	$753.35	$743.27	$1,284.17
53	$703.35	$697.87	$657.65	$1,212.52	$787.32	$776.78	$1,342.06
54	$736.10	$730.37	$688.27	$1,268.98	$823.98	$812.95	$1,404.56
55	$768.85	$762.87	$718.90	$1,325.45	$860.65	$849.12	$1,467.06
56	$804.37	$798.10	$752.10	$1,386.67	$900.40	$888.34	$1,534.82
57	$840.22	$833.68	$785.63	$1,448.48	$940.53	$927.94	$1,603.24
58	$878.49	$871.65	$821.41	$1,514.46	$983.37	$970.21	$1,676.26
59	$897.46	$890.47	$839.14	$1,547.15	$1,004.60	$991.15	$1,712.45
60	$935.73	$928.44	$874.93	$1,613.12	$1,047.44	$1,033.42	$1,785.47
61	$968.82	$961.28	$905.87	$1,670.18	$1,084.49	$1,069.97	$1,848.63
62	$990.55	$982.83	$926.18	$1,707.63	$1,108.80	$1,093.96	$1,890.07
63	$1,017.78	$1,009.86	$951.65	$1,754.58	$1,139.29	$1,124.04	$1,942.04
64+	$1,034.34	$1,026.27	$967.14	$1,783.11	$1,157.82	$1,142.31	$1,973.61

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Below is a listing of all ZIP codes within Rate Areas 7, 9

County	Rate Area										
Santa Clara	7	94022-24	94301-06	95008-09	95026	95044	95076	95108-13	95150-61	95190-94	
		94035	94309	95011	95030-33	95046	95101	95115-36	95164	95196	
		94039-43	94550	95013-15	95035-38	95050-56	95103	95138-41	95170		
		94085-89	95002	95020-21	95042	95070-71	95106	95148	95172-73		
Monterey	9										
San Benito	9										
Santa Cruz	9	95001	95003	95005-07	95010	95017-19	95033	95041	95060-67	95073	95076-77

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