KAISER PERMANENTE®

All plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Oregon Small Group Renewal Decision Form

Return of this form is required by the 15th of the month before the renewal date. No response will result in inability to make eligibility and benefit plan changes.

Please submit via 1 of the following methods:

Email: small.group.respond@kp.org
Fax: 1-877-237-5548
Mail: 500 NE Multnomah St., Portland, OR 97232

Group Name: _____ Group #: _____

Renewal Date: _____ Account Manager: _____ Phone: _____

Open Enrollment — Your open enrollment period is the month before your renewal effective date. This time period allows employees and/or their dependents, including those who previously declined coverage, to enroll. If you offer more than 1 medical plan, employees who would like to make a plan change among the plans you currently offer may do so at this time. For groups with multiple plans, existing employees may make a plan change among the plans you currently offer. We must receive notice of any new enrollments or plan changes by the end of the month before your renewal date.

Dental Coverage — If you do not currently offer Kaiser Permanente Family Dental coverage, it may be added at renewal. Dental plan options and rates for employers are included with this renewal.

MEDICAL BENEFITS/Renewal Choice

Number of plan offerings: ☐ 1 plan ☐ 2 plans ☐ 3 plans

	RENEWAL OFFERING	RENEW as offered	CHANGE to a new plan selection	NEW PLAN SELECTION	Vision	Vision & Massage	HSA/HRA/FSA Selection(s) Yes (Y) or No (N)
First Plan		☐	☐		☐	☐	
Second Plan		☐	☐		☐	☐	
Third Plan		☐	☐		☐	☐	
Out-of-Area*		☐	☐		☐	☐	

*For eligibility requirements, please refer to the 2024 rating and underwriting assumptions policy or speak with your account manager.

High Deductible Health Plans (HDHPs) are health savings account (HSA) qualified. If you selected an HDHP medical plan above, please indicate if you'd also like Kaiser Permanente to administer your HSA health payment account. **If you select Yes, a Kaiser Permanente representative will contact you to provide more information on your next steps, as additional documents and administrative fees apply.**

HSA administered though Kaiser Permanente? ☐ Yes ☐ No

DENTAL BENEFITS/Renewal Choice

Number of plan offerings: ☐ 1 plan ☐ 2 plans

All employer-sponsored dental plans are available to groups of 1 to 50 employees and a minimum of 2 members enrolled. Groups may only offer 1 Traditional and/or 1 Choice PPO family dental plan. Additional employee enrollment forms are required to **add** dental coverage. Please submit those employee enrollment forms along with this form. See the 2024 rating and underwriting assumptions policy for voluntary dental plan offering requirements.

	RENEWAL OFFERING	RENEW as offered	CHANGE to a new plan selection	NEW PLAN SELECTION
First Plan (family)		☐	☐	
Second Plan (family)		☐	☐	

Group Name: _____ Group Number: _____

PEDIATRIC DENTAL COVERAGE ATTESTATION

We are required to include pediatric dental benefits with your medical plan(s). By enrolling in a Kaiser Permanente medical plan, each employee and each of his/her dependents will have access to a separate pediatric dental plan, unless you confirm (below) that you have purchased other pediatric dental coverage compliant with the Affordable Care Act or offer family dental coverage. We will rely on your confirmation. If no attestation is provided and no plan is selected, we will enroll your group in the lowest cost pediatric dental plan. Premium will be applied to pediatric members under the age of 19, who are not enrolled in a family dental plan.

☐ Enroll my group in the pediatric dental plan along with the Small Business Medical Plan that I have chosen.

☐ I have purchased other pediatric dental coverage. (If you currently have a standalone pediatric dental plan in place, checking this box will terminate the coverage listed below).

	RENEWAL OFFERING	RENEW as offered	CHANGE to a new plan selection	NEW PLAN SELECTION
Pediatric Plan		☐	☐	

ELIGIBILITY AND CONTRIBUTIONS

Complete items 1 through 4.

1. Hourly requirement for benefits:

Weekly _____

2. Employer contribution:

Employee _____%/$

Dependent _____%/$

3. Domestic partner coverage election:

☐ No change ☐ Add ☐ Remove

4. Employee only plan (no dependents can enroll):

☐ No change ☐ Yes ☐ No

CONFIRMATION AND BILLING

You can find a Group Policy Overview/Confirmation in this packet reflecting your plans and rates if you make no changes. If you make changes during open enrollment, you will receive an updated confirmation reflecting your renewal decision after the effective date of the new policy. This will confirm your plan information and new rates. Please notify your account manager within 10 days after receipt of the confirmation if there are any discrepancies or if any corrections need to be made.

Your new rates will be reflected on your invoice, in your **account.kp.org** employer portal, in the next available billing cycle after the change is processed in our system. Invoices are generated around the 10th of each month.

SIGNATURE

_____ _____

SIGNATURE OF EMPLOYER OR PRODUCER DATE

_____ _____

TITLE (IF PRODUCER, LIST AGENCY) EMPLOYER'S EMAIL ADDRESS

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