

Open Enrollment Non-Federally Eligible Individuals

Information on Open Enrollment Eligibility

In compliance with the Ohio Department of Insurance, Kaiser Permanente is pleased to offer health care coverage to individuals who are not federally eligible for coverage. Enclosed is information regarding our Open Enrollment Basic and Standard Plans for non-federally eligible individuals. Read the disclosure information carefully to determine if you qualify for Open Enrollment coverage and select the benefit package, Basic or Standard, which best suits your needs.

Ohio law requires us to accept a certain number of individuals for open enrollment coverage without regard to health status. However, we are not required to accept applicants who at the time of enrollment, are confined to a health care facility due to chronic illness or permanent injury. If you qualify as a Federally Eligible Individual (FEI), see HIPAA information in this packet. If you do not qualify as a FEI, you may apply for non-Federally Eligible Individual (non-FEI) Open Enrollment coverage. If we have not yet met our enrollment quota, we will offer you the Open Enrollment Basic or Standard benefit plans for purchase.

To be eligible for enrollment in one of our non-federally eligible Plans, complete the questionnaire and return it in the enclosed envelope along with your payment for the first month's premium. Membership will be offered to applicants deemed eligible.

If you have any questions, please call the Direct Consumer Sales Department at **1-800-524-7371 ext. 5613**, Monday through Friday 8:15 a.m. – 5:00 p.m. (EST).

DISCLOSURE INFORMATION RULES FOR DETERMINING WHETHER YOU ARE NON-FEI OR FEI

You are a non-FEI if you meet all of the following conditions:

1. You are not applying for coverage as an employee of an employer, member of an association, or member of any other group.
2. You do not have any other health coverage and are not eligible to be covered under any private or public health benefit plans including the following: a) Medicare or Medicare supplement policy, b) Medicaid, c) any COBRA or state continuation coverage plan, d) other health benefits arrangement.

You are a FEI if you meet all of the following conditions:

1. You had health coverage for at least 18 months without a break in coverage greater than 63 days.
2. Your most recent health coverage was under a group health plan, governmental plan or church plan.
3. You are not eligible for coverage under any of the following plans: a) a group health plan, b) Medicare, c) Medicaid.
4. You do not have any other health coverage.
5. Your most recent health coverage was not terminated because of nonpayment of premiums or fraud.
6. If you had been offered the option to continue coverage under COBRA or a state continuation plan, you both elected and exhausted the continuation coverage.



HIPAA Federally Eligible Individuals

Information on HIPAA Eligibility

In compliance with the Ohio Department of Insurance, Kaiser Permanente is pleased to offer health care coverage to individuals who are federally eligible for coverage according to the Health Insurance Portability and Accountability Act (HIPAA). Enclosed is information regarding our Basic and Standard Plans for federally eligible individuals. Read the disclosure information carefully to determine if you have creditable coverage and select the benefits package which best fits your needs.

To be eligible for enrollment in a federally eligible HIPAA Plan, complete the questionnaire and return it in the enclosed envelope along with your payment for the first month's premium. **You must also provide proof of prior coverage (Certificate(s) of Creditable Coverage) from previous employers or providers of health care coverage.** Membership will be offered to applicants deemed federally eligible.

If you have any questions, please call the Direct Consumer Sales Department, Monday through Friday, 8:15 a.m. to 5:00 p.m. (EST) at **1-800-524-7371 ext. 5613**.

DISCLOSURE INFORMATION RULES FOR DETERMINING WHETHER YOU HAVE 18 MONTHS OF CREDITABLE COVERAGE:

The term "creditable coverage" as used in this request for coverage means health care coverage provided in connection with any of the following: a contract or policy providing hospital, surgical or medical benefits issued by a licensed disability insurance company or health care service plan, non-profit hospital service plan, fraternal beneficiary society, self-insured employer plan, or any other entity that arranges or provides medical, hospital, or surgical coverage not designed to supplement other private or government plans; Part A or Part B of Medicare, or the Medicare Program under Title XIX of the Social Security Act (referred to in this Application as "Medicaid"), unless coverage was limited to pediatric vaccines; a program or plan established or maintained by a state government (or political subdivision thereof), the Indian Health Services, or tribal organization, that provides hospital, surgical, or medical benefits to enrollees; a plan offered by the Federal Employees Health Benefits Program, the federal Civilian Health & Medical Program of the Uniformed Services, the Peace Corps, or an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974, and all amendments thereto (referred to in this Application as "ERISA"), that provides coverage for medical care; and any other form of health coverage that Ohio or federal law defines as creditable coverage for purposes of implementing Part B of the Health Insurance Portability and Accountability Act of 1996, codified at 42 U.S.C. section 300gg-41, et seq. (hereinafter referred to as "HIPAA").

Notwithstanding the above, the following forms of health care coverage are not creditable coverage: accident only; coverage for on-site medical clinics; disability income; Medicare supplemental; long-term care; dental; vision; credit; workers' compensation; automobile medical payment; coverage issued as a supplement to liability insurance; insurance which is payable with or without regard to fault and that is legally required to be contained in any policy of liability insurance; and any other insurance or coverage that state or federal law indicates is not creditable coverage for purposes or implementing HIPAA.

Consecutive periods of creditable coverage can be added together provided a "significant break" between them has not occurred. For purposes of this Application, a "**significant break**" occurs if 63 consecutive days pass between the date one period of creditable coverage ends and the earlier of either:

- 1) The date on which a substantially completed application of health care coverage was submitted to any insurer for a succeeding period of creditable coverage which became effective or
- 2) The first day of an employer-imposed waiting period or an affiliation period applicable to that succeeding coverage.

If a significant break in creditable coverage has occurred, all periods of creditable coverage before that significant break are disallowed and you cannot include those days in determining whether you have 18 months of creditable coverage.

Periods of an employer-imposed waiting period or affiliation period do not count as periods of creditable coverage. If you have more than one source of creditable coverage on the same day, all the creditable coverage for that day counts as a single day of creditable coverage.

Your former employee benefit plan or issuer of health care coverage must provide you a certificate demonstrating the time periods you were insured or had health care coverage so that you can prove that you have the minimum amount of creditable coverage required. This is called a **"Certificate of Creditable Coverage."** If you do not have or cannot obtain a Certificate of Creditable Coverage, certification information may be obtained by other means.